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OLDER AMERICANS ACT OF 1987

HEARINGS

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

S. 887

TO EXTEND THE AUTHORIZATION OF APPROPRIATIONS FOR AND TO STRENGTHEN THE PROVISIONS OF THE OLDER AMERICANS ACT OF 1965, AND FOR OTHER PURPOSES

MARCH 31, APRIL 23, AND 30, 1987

Printed for the use of the Committee on Labor and Human Resources

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OLDER AMERICANS ACT OF 1987

TUESDAY, MARCH 31, 1987

U.S. Senate,
Subcommittee on Aging,
Committee on Labor and Human Resources,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:07 p.m., in room SD-430, Dirksen Senate Office Building, Senator Spark M. Matsunaga (chairman of the subcommittee) presiding.

Present: Senators Matsunaga, Pell, Cochran, Metzenbaum, and Thurmond.

OPENING STATEMENT OF SENATOR MATSUNAGA

Senator **Matsunaga**. The Subcommittee on Aging of the Committee on Labor and Human Resources will come to order.

Good afternoon, everyone.

This is the first in a series of three hearings to be held by the Subcommittee on Aging to examine issues regarding the 1987 reauthorization of the Older Americans Act of 1965. Today's hearings will address changing needs of the elderly, including specific recommendations to meet such needs.

The Subcommittee's second hearing will examine the participation of older minority groups in the benefits and services under the Act, and the third will examine the implementation and management of current services funded by the Act and ways in which they can be improved.

The Older Americans Act was a landmark piece of legislation when it was originally enacted in 1965. Through this legislation, Congress created a new Federal program specifically designed to address the social service needs of the elderly.

However, beyond the scope of the relatively small service programs created at that time, Congress established a framework for a national policy on aging. The original Act set forth 10 national policy objectives aimed at improving the lives of older persons in areas of income, health, housing, employment, retirement, and community services. Congress also created the Administration on Aging, which was directed to stimulate more effective use of existing resources for older persons.

As the Act has evolved through its successive reauthorizations and amendments, it has become the cornerstone for the development and delivery of a broad array of services for older persons. While older persons may receive services under a multiplicity of other Federal programs, the Act is viewed as the major vehicle for the organization and delivery of services to older Americans. Major amendments in 1972 and 1973 created the national nutrition program for the elderly and the network of area agencies on aging.

The 1973 amendments folded authority for the community service employment program for low income older persons under the auspices of the Act, and the 1978 amendments streamlined the various service programs and added a new service program for older Indians.

Subsequent amendments have expanded the authority and responsibilities of State and area agencies on aging. During the period of 22 years since enactment, the Act has evolved from a program of small grants to one that now supports 57 State agencies on aging and over 660 area agencies on aging. Annual appropriations have grown from $6 million to $1.2 billion.

In order to plan for the future development of the programs authorized under the Act, it is important to examine the needs of the elderly population, how they have changed, and how they are predicted to change in the future. The purpose of this hearing is to assess some of the factors which will have significance for the Older Americans Act over the next several years.

We are all familiar with the demographic facts about the aging of the Nation's population. The elderly population has grown more rapidly in this century than has the remainder of the population, and the trend is predicted to continue into the 21st century. Between 1980 and the year 2020, the total population in the United States is projected to increase by slightly more 30 percent, while the elderly population is projected to increase by more than 200 percent.

One of the more critical demographic factors to be considered in our future planning is the startling pace of increase among the oldest segment of our society. Persons 85 years of age and older are now the fastest growing age group. This factor may have significant implications for continued and expanded support for services authorized and funded under the Act, especially those services which assist older persons to remain in their own homes.

Other characteristics of the elderly population are important to consider in planning for the future. Over the last two decades, we have seen dramatic improvements in the economic status of the elderly in terms of poverty rates overall. However, there are certain groups of the elderly who are substantially at greater risk of poverty, including older women, minorities, and the very old.

We fully expect that the scheduled hearings will be helpful to the Subcommittee in examining some of the more important changes in the needs of the elderly.

I wish now to recognize the distinguished ranking member of the full Committee, Senator Pell. If you have any opening remarks, Senator, we will be happy to hear from you before you introduce the witness who hails from your State.

OPENING STATEMENT OF SENATOR PELL

Senator PELL. Thank you very much, indeed, Mr. Chairman. I guess you and I are amongst the older Americans who are here and the witness I am introducing is not yet an older American under the definition, and it is really a great pleasure and delight to introduce to the Subcommittee the Honorable Edward DiPrete, Governor of the State of Rhode Island.

Governor DiPrete comes before us today with a wealth of experience and leadership in making government work for all of our people, including our senior citizens, and his public service dates back to 1971, when he was first elected as a member of the City of Cranston School Committee. Cranston is one of our State's largest cities and Ed DiPrete served the citizens well and became a member of the City Council and then Mayor.

Mayor DiPrete soon gained a reputation as a man of great integrity, and his abilities and reputation led to his election as our Governor in 1984. Governor DiPrete has brought to his new office the same work ethic and energy that served him so well as Mayor. He was reelected to a second term as Governor this past November by a large majority.

As a Member of the National Governors Association's Committee on Human Resources, Governor DiPrete is well versed in the problems facing our Nation's elderly population. Governor DiPrete and the other Governors on the Human Resources Committee of the National Governors Association have put together a position paper on the Older Americans Act that I for one believe is a hundred percent on target. It emphasizes reauthorization and two changes, in-home services for the functionally impaired seniors and a defined structure of preventive services.

I look forward to hearing Governor DiPrete's testimony today and I am very glad to join you, Mr. Chairman, in welcoming him here.

Governor DiPrete.

Governor **DiPrete**. Thank you, Senator Pell. Thank you, Mr. Chairman.

Senator **Matsunaga**. Governor, we would be happy to hear from you. As I understand it, you are testifying here in behalf of the National Governors' Association?

Governor **DiPrete**. That is correct, Mr. Chairman. The remarks that I will be making are on behalf of the National Governors' Association.

Senator **Matsunaga**. We would be happy to hear from you.

STATEMENT OF HON. EDWARD D. DiPRETE, GOVERNOR OF RHODE ISLAND, ON BEHALF OF THE NATIONAL GOVERNORS' ASSOCIATION

Governor **DiPrete**. I certainly appreciate the opportunity to testify on behalf of my colleagues, and I might say I am particularly delighted to be testifying on the Older Americans Act, because former Congressman John Fogarty, from Rhode Island, was one of its principal sponsors when it was first enacted in the year 1965.

I might say to begin with that the National Governors' Association strongly supports reauthorization of the Older Americans Act. Over the past decades, the Act has helped to create a network of people and organizations which provide invaluable assistance to America's elderly.

The Governors believe, however, that the Older Americans Act must change as America's elderly population increases as a proportion of the total population. While many of the new elderly may be healthy, a growing number, particularly those over 85, will need more help with activities of daily living.

In addition, then, to continuing the provisions of the current Act, the Nation's Governors are proposing several major amendments which would help meet essential and growing needs of the elderly population.

The first change is in direct response to the increasing age of our elderly population. We propose a new authorization in Title III of the Act to strength State efforts to provide in-home services. We suggest this new authorization take into account factors such as the number of elderly over age 75 and over age 85, the estimated number suffering from Alzheimer's and related diseases, the number of elderly who are impaired in three or more activities of daily living, and the number of elderly who are minorities.

We commend Senator Metzenbaum for his proposal in S. 81 to provide home and community-based services to the frail elderly with Alzheimer's and related dimentia. It is very similar to our own proposal. However, a new authorization for in-home services should be broad enough to allow services, regardless of the cause of that need. Many elderly need assistance as a result of heart or muscle diseases, in addition to dimentia. Further, our proposal would require the same 15 percent State match required in other Title III programs, whereas S. 81 would require a State match that could be as high as 40 percent.

Now, my written testimony filed with the Subcommittee details three compelling reasons to increase support of in-home services to the frail elderly. The reasons can be summarized as follows:

The increasing age of our elderly population: By the year 2010, there are expected to be 7.1 million more elderly over the age of 75. That includes 3.9 million over the age of 85, compared to 1985.

The shorter hospital stays that are resulting from the new Medicare prospective payment system and the increase in the number of senior citizens with functional impairments are currently estimated at 4.6 million elderly people.

Secondly, the Governors urge you to increase Older Americans Act support for preventive health services. We are convinced that reducing the need for intensive health care is not only cost effective, but it is compassionate. Title VII of the Act could be funded and restructured to provide Federal matching funds to States for preventive health services.

A specific package of preventive services addressing leading health problems that cause functional impairments in daily living, such as arthritis, hypertensive disease, hearing, and other problems, is envisioned.

The Governors' third major proposal is to permit State initiatives to develop new resources for elderly programs. Those with high incomes can share in the cost of services they receive. States could then use the increased revenue to serve more elderly. States should be permitted to develop cost sharing approaches for services other than nutrition programs. These arrangements should be on a sliding scale based on the ability to pay.

Rhode Island, for example, has an excellent record in soliciting voluntary contributions for the senior nutrition program. During fiscal 1986, older persons contributed an average of 90 cents for every meal served.

In addition to these new initiatives, the Governors want to maintain and/or strengthen the current services and research funded through Titles III, IV, and V of the Act.

A summary of our specific recommendations are as follows:

To oppose Federal targeting through set-asides;

To retain the Governors' responsibility to structure the long-term care ombudsman program to assure its independence and integrity;

To maintain the State responsibility for coordination and integration of community-based, long-term care services; we particularly oppose eliminating State authority to decide whether or not to authorize Area Agencies on Aging;

We require that the national contractors and State agencies operating Title V community service employment programs develop a Statewide plan, to be approved by the Governor;

To require State input into federally financed research and demonstration projects funded through Title IV. We believe that research and demonstration projects should support innovative approaches to services and encourage new approaches to intergovernmental activities that better integrate the elderly into our society.

Mr. Chairman and Senator, I want to thank you again for inviting me to testify on behalf of the National Governors' Association before you today. We look forward to working with you to find solutions to the long-term care of America's growing elderly population.

The Governors believe that a vibrant aging network, with new authority for in-home and preventive health services, and authority to secure new resources in a reauthorized Older Americans Act is an excellent first step. We as an association offer our help and assistance with this reauthorization effort.

Thank you, Mr. Chairman.

[The prepared statement of Governor DiPrete follows:]

National Governors' Association

Bill Clinton
Governor of Arkansas
Chairman

Raymond C. Scheppach
Executive Director

STATEMENT OF

THE HONORABLE EDWARD D. DIPRETE
GOVERNOR OF RHODE ISLAND

on behalf of

THE NATIONAL GOVERNORS' ASSOCIATION

before the

SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

regarding

REAUTHORIZATION OF THE OLDER AMERICANS ACT

March 31, 1987

HALL OF THE STATES · 444 North Capitol Street · Washington, D.C. 20001-1572 · (202) 624-5300

Mr. Chairman and Members of the Subcommittee, I very much appreciate the opportunity to testify on behalf of the nation's Governors regarding the Older Americans Act (OAA). I am particularly delighted to be testifying on the Older Americans Act because Rep. John Fogarty of Rhode Island was one of its principal sponsors when it was enacted in 1965.

The National Governors' Association strongly supports reauthorization of the Older Americans Act. While other federal programs serve the elderly, NGA believes that the Older Americans Act is essential in the continuum of services for the elderly. The Governors therefore are pleased to see a general consensus that the basic OAA programs for social services, nutrition and employment should be continued at least at current levels of funding.

The Governors believe, however, that the Older Americans Act must change as America's elderly population increases as a proportion of the population, particularly with larger numbers over age 85. While many of the new elderly may be healthy, a growing number, particularly those over 85, will need more help with activities of daily living.

To respond to the needs of this growing group, the Governors have called for a new authorization in Title III of the act to strengthen state efforts to provide in-home services to the elderly. To complement this suggestion, NGA believes that the Older Americans Act should increase support to prevent the problems that lead to functional impairment. Finally, we ask for the authority to develop cost-sharing arrangements with those elderly who are able to pay for services.

There are three compelling reasons to increase OAA support for in-home services to the frail elderly:

o First, in the year 2010, there are expected to be 7.1 million more elderly over age 75, including 3.9 million over age 85, than in 1985. Moreover, in 2010, the life expectancy at age 65 is expected to be 86.1 for females and 81.1 for males. The elderly population will increase to about 21 percent of the population in the year 2030, up from 12 percent in 1985. About 16 percent of the elderly will be over age 85, up from 9 percent in 1985.

- Second, the new Medicare prospective payment system may be resulting in some patients being discharged sooner and in poorer health than before. The length of stay for all Medicare short-stay hospital discharges in fiscal 1984 was 9 percent lower than in fiscal 1983. Experts in the field of aging clearly believe that the prospective payment system is increasing demand for in-home services due to early releases of patients from hospitals.

- Third, it is clear that over the next several decades the number of elderly with functional impairments will increase. The 1982 National Long-Term Care Survey showed that approximately 4.6 million elderly living in the community needed help with at least one activity of daily living, including about 1 million who exhibited severe functional impairments in performing such activities as cooking, dressing, bathing, and getting into and out of bed. The survey found that these needs increased with age: about 12.6 percent of persons age 65-74 needed such assistance, but about 46 percent of those over 85 needed it. The General Accounting Office reports that researchers forecast that from 1980 to 1995, the number of elderly with disabilities will increase 45 percent, and the most severely disabled group by 49 percent.

We suggest that the new authorization in Title III take into account factors such as the number of elderly over age 75 and over age 85, the estimated number suffering from Alzheimer's and related diseases, the number of elderly who are impaired in three or more activities of daily living, and the number of elderly who are minorities. In addition, we believe states should use these and related factors when determining who is eligible to receive in-home assistance under this new authorization. Moreover, we believe all other Title III requirements and options should apply to this new part.

We commend Senator Metzenbaum for his proposal in S.81 to provide home and community-based services to the frail elderly with Alzheimer's and related dimentia. It is very similar to our proposal. However, a new authorization for in-home services should be broad enough to allow services to elderly Americans who need help with activities of daily living regardless of the cause of that need. Many elderly need assistance as a result of heart or muscle diseases, in addition to dimentia. Further, our proposal would require the same 15 percent state match required in other Title III programs, whereas S.81 would require a state match as high as 40 percent.

The Governors also urge you to increase Older Americans Act support for preventive health services. We are convinced that preventing the need for intensive health services is not only cost-effective, but compassionate. Title VII of the act, which has not been funded since it was added to the OAA in 1984, could be restructured to provide federal matching funds to states for preventive health services. A specific package of preventive services, including physical examinations, influenza vaccinations and appropriate testing, screening, and health education is envisioned. Leading health problems that cause functional impairments in daily living -- arthritis, hypertensive disease, hearing, dementia, and musculoskeletal diseases -- may be reduced through preventive services. To increase accessibility, NGA policy suggests that such services be provided through senior centers.

The Governors' third major proposal is to permit state initiatives to develop new resources for OAA programs. It is time to recognize that the elderly with high incomes can share in the cost of services they receive, and that states can use the increased revenue to serve more elderly. States should be permitted to develop cost-sharing approaches for services other than nutrition programs. These arrangements should be on a sliding scale based upon ability to pay.

This approach is not new. In fact, cost-sharing is an accepted practice in Medicare and many state-financed programs for the elderly. The Illinois Community Care Program is an excellent example of a program that charges on a sliding scale for services such as homemaking and adult day care. This program sets a threshold income level below which no fee is charged. Of the 25,000 persons receiving services from the program, half are below the threshold. The half above the threshold are charged for services.

States should be permitted to continue to seek voluntary contributions for meal programs and social services. Rhode Island, for example, has an excellent record in soliciting voluntary contributions for the senior nutrition program. During fiscal 1986, older persons contributed an average of 90 cents for every meal served.

In addition to these new initiatives, the Governors want to maintain and/or strengthen the current services and research funded through Titles III, IV, and V of the act. Our specific recommendations are:

- To maintain current federal law which does not target through set-asides, or interstate or intrastate funding formulas.

- To retain the Governors' responsibility to structure the long-term care ombudsman program to assure its independence and integrity. We would support a provision in Title III to permit states that fund the ombudsman with state funds to waive the set-aside requirement, as long as state funding at least equals the set-aside amount.

- To maintain the state responsibility for coordination and integration of community-based, long-term care services. We particularly oppose eliminating state authority to decide whether or not to authorize Area Agencies on Aging to provide direct services, such as case management. Rhode Island and Delaware are the two states that do not have area agencies, but administer programs under one state agency. However, we are most sensitive to the needs of the other 48 states, and their need to retain this authority. The Governors believe that the state role in the OAA network is to first and foremost coordinate services among state, local, and private sector programs, and to prevent duplication. This should be continued.

- To require that the national contractors and state agencies operating Title V community service employment programs develop a statewide plan, to be approved by the Governor. National contractors should not have the sole discretion to determine the location of community service job slots for the elderly within states. The state agencies on aging should be co-equal partners in these decisions, and the Governor should approve a written agreement among all contractors and the state. This procedure will assure coordination with other jobs programs and should lead to a fair distribution of job opportunities throughout each state. In states where relations between the aging agency and the contractors are congenial, obtaining gubernatorial approval should not be a problem. The need for this simple and logical procedure is evident when one realizes that in 31 states, there are four or more national contractors operating independent programs. In Pennsylvania alone, there are eight contractors, and three states each have seven national contractors. While in some states the contractors may have a good working relationship with the state aging agency, we believe there is a need to formalize the relationship in writing.

- To require state input into federally financed research and demonstration projects funded through Title IV. We believe that research and demonstration projects should support innovative approaches to services and encourage new approaches to intergenerational activities that better integrate the elderly into society.

I want to thank you again for inviting the National Governors' Association to testify before you today. We look forward to working with you to find solutions to the long-term care needs of America's growing elderly population. We believe that a vibrant aging network--with new authority for in-home and preventive health services and authority to secure new resources--in a reauthorized Older Americans Act is an excellent first step. We offer our help and assistance with this reauthorization effort.

Senator MATSUNAGA. Thank you very much, Governor DiPrete. I wish to recognize the presence of the ranking minority member of the Subcommittee. Do you have any opening statements, Senator Cochran?

OPENING STATEMENT OF SENATOR COCHRAN

Senator COCHRAN. Mr. Chairman, thank you very much. Let me just say at the outset that we appreciate your convening this hearing, the first in a series that will examine the Older Americans Act and the obligation that we have this year to reauthorize this legislation and this program.

I know that the testimony we are going to hear in this series of hearings is going to be very helpful to us in trying to identify ways to improve the Act, if that can be done, and to place emphasis in certain areas that are not emphasized now in the legislation.

But I think we are in agreement as we begin the hearings that this is one of the most important legislative initiatives that the Federal Government has approved in many years. It shows a sensitivity, a caring for the elderly population, for the special needs that many have in that group, and I am interested in insuring, through my work with the Chairman and the other members of this Subcommittee, that our recommendations to the full Committee and to the Senate are the best that they can be, and these hearings are essential as a part of that process.

We appreciate your being here, Governor DiPrete, representing the Governors Association.

I will defer my questions until the Chairman has had an opportunity to ask his question. Thank you, Mr. Chairman.

Senator MATSUNAGA. Thank you, Senator Cochran.

Governor, I understand that Rhode Island has the second highest percentage of elderly in the country. It seems to me that Rhode Island has already begun to face many of the issues that other States will come to face in the next few decades. Now, can you give us your perspective on how these demographic shifts have affected the demand for government and community services in your State? Perhaps we could apply it at the national level.

Governor DIPRETE. Yes, I would be happy to, Mr. Chairman.

We have seen over the past several years, as Mayor beginning in 1979 and as Governor since 1984, a growing and constant demand for the services that we feel our elderly can justifiably expect to receive from government, particularly in the area of nutrition and transportation.

But one of the areas that we see an increasing call for—and this is what I addressed in my remarks earlier—is help for in-home and preventive assistance, preventive medical treatment. In-home care we think is particularly important with the growing elderly population, particularly in the 75 to 85 and over age bracket. We feel that by providing in-home care we can keep the elderly people in with their families, in their own home and familiar surroundings, with a familiar environment. We think that is more compassionate and naturally we think it is even more cost effective, to be able to render this kind of assistance than to look for an alternative such as institutional care.

Senator **Matsunaga**. Have you any projection as to the cost per capita per annum for in-home care for the elderly?

Governor **DiPrete**. Well, it is hard to put a figure on it, Senator. I could say that our proposal from the Governors' Association is recommending that initially these initiatives be funded with an allocation of some $25 million, mostly for in-home care, but some for medical prevention. I would venture to say that, while I cannot give you a per capita cost, I could say collectively it is an increasing cost that we share to the best of our ability, but we cannot meet the demand.

Senator **Matsunaga**. Senator Cochran, do you have any questions of the Governor?

Senator **Cochran**. I was wondering whether or not the association has looked at the possibility of expanding the Public Health Service Act to try to help solve this problem of in-home health care, whether or not that would be a vehicle to review, as well as the Older Americans Act, for the purpose of enlarging the access to home health care?

Governor **DiPrete**. Senator Cochran, I can say that, yes, alternatives were considered and I think the feeling of the Governors' Association as an organization feels that each of the individual programs that benefit our older Americans, whether it be Social Security, Medicare, Medicaid, all of the programs collectively have a specifically defined purpose, and the Governors felt that the Older Americans Act was the proper vehicle to extend somewhat to provide for in-home and preventive health services. Yes, we did consider the alternatives.

We know that some States and some communities already on their own are financing in a very limited way these services, but with the growing population, I just do not think the States would have the resources to handle this by themselves.

Senator **Cochran**. Thank you very much, Mr. Chairman.

Thank you very much for your help to the Committee.

Governor **DiPrete**. Thank you.

Senator **Matsunaga**. Thank you, Senator Cochran.

I wish to recognize the presence of Senator Metzenbaum. Senator, do you have an opening statement or questions of Governor DiPrete?

Senator **Metzenbaum**. I have a short opening statement, if I might.

Senator **Matsunaga**. Please proceed.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator **Metzenbaum**. Thank you. First of all, I want to commend you for holding this hearing. I am particularly pleased that Governor DiPrete is here with us and Senator Claiborne Pell. We were to have a very distinguished witness from Ohio, but they tell me that there is more snow there than they have had in the last thirty years and he will not be with us today.

This series of hearings on the reauthorization of the Older Americans Act is early in the session and I think it is appropriate that it is so. This Act has played an important role in providing for services to give older persons options for continued independence, and I believe there is a consensus for reauthorization.

I am hoping, however, that this Subcommittee will strengthen the Act in several ways, but specifically by authorizing expansion and further development of home community-based services for victims of Alzheimer's disease. I know of no illness in this country that has more moved the people of the country whose lives it has touched and the families of those with Alzheimer's than this particular illness.

Twenty years ago, nobody talked about Alzheimer's. Today, you can hardly travel to any corner of the community in which somebody's life has not been affected by Alzheimer's.

I introduced on January 6th of this year S. 81, the Alzheimer's Disease and Related Dementias Home and Community Based Services Block Grant Act. It is enthusiastically supported by the National Voluntary Organization of Care Giver Families, the Alzheimer's Disease and Related Disorders Association, representing 2.5 to 3 million care givers' families, by the Ohio Association of Adult Day Care—and it is my understanding before I arrived, Mr. DiPrete, you were good enough to indicate that you support it as well.

Governor DiPRETE. Yes, Senator, correct.

Senator METZENBAUM. That pleases me much.

This measure provides for adult day care, respite care in and out of the home, case management and information referral services, pre-nursing home admission counseling to delay institutionalization, homemaker assistance, transportation, and other needed services.

You know, as I recite those words, Mr. Chairman, I say to myself, you know, they are just words until they affect your life or the life of somebody close to you. When you talk about case management and information and referral services, it is a nice phrase but it does not mean much until you need that kind of assistance. And each of the other phrased terms can have such an impact upon the kind of care we give and the help that we provide to the families of those who have been affected by this illness.

In preparation for these hearings, I invited the aging agencies from my State of Ohio to review the Act and its implementation and to send me their recommendations for improving and strengthening services to our older Americans. They inform me of the need for expansion and further development of services for victims of Alzheimer's disease and their families. Their need for such services is documented by the area agencies and by ADRDA, and provision of such services is supported by many national associations of senior citizens.

We know there are serious gaps in needed services at all the different stages of the disease and, given the demographics of an aging population, the future could well be even more grim, for twice as many health and long-term care services as are presently available will be needed when our baby boomers turn 65. That is a shocking statistic.

The care giving required for Alzheimer's disease patients has been described as a 36-hour day. The impact on care givers is devastating. We must begin now to provide the social supports for continued family care giving. Now our institutions and health care systems are overwhelmed with increasingly large numbers of demented adults and our nation is overwhelmed with colossal costs of hundreds of billions of dollars.

It is my hope, Mr. Chairman, that S. 81 will be included in the final reauthorization of the Act. In addition, this Committee may want to consider several other recommendations offered by aging organizations of my State and by national associations for improving the Act. The recommendations involve fine-tuning, rather than basic structural changes, and I hope we will address some of them well.

I look forward to the testimony of the witnesses and I look forward to working with you, Mr. Chairman, and all of the other members of this Committee.

Thank you.

Senator MATSUNAGA. Thank you very much, Senator Metzenbaum.

Governor, do you have any other remarks you would like to make before leaving the witness chair?

Governor DIPRETE. No, Mr. Chairman. As I mentioned, in addition to my oral remarks, I have filed a more detailed, complete statement on behalf of the National Governor's Association, and I certainly thank you for the opportunity to express those views.

Senator MATSUNAGA. Your written statement will appear in the hearing record as though presented in full.

Governor DIPRETE. Thank you, sir.

Senator MATSUNAGA. I might point out that relative to Alzheimer's disease, the 1984 amendments to the Older Americans Act amended both Title III and Title IV in order to focus attention on the needs of Alzheimer's victims and their families, and the law amended Title III to include, within the priority service category of in-home services, reference to supportive services for families of victims. In addition, the amendments required the Commissioner on Aging to give special consideration to training and demonstration projects that would serve Alzheimer's victims. In the process of reenacting the Older Americans Act of 1965, as it is now currently on our books, we will definitely look into the proposal of Senator Metzenbaum and how it relates to existing law.

Thank you again. Thank you very much.

Governor DIPRETE. Thank you, Mr. Chairman. Thank you, Senator Metzenbaum and Senator Cochran.

Senator MATSUNAGA. We are just about ready to have a vote on the floor and we will have back-to-back votes on four questions, which means that once the voting begins we will be gone for about 45 minutes. Perhaps until such time as the first vote begins, we can take our next panel.

Our next panel of witnesses will be presenting some additional perspectives on the changing needs of the elderly. I would like to extend a warm welcome to Dr. Jeanette Takamura, Director of the State of Hawaii Executive Office on Aging, and Dr. C. Kermit Phelps, Chairman of the Board of the American Association of Retired Persons.

Dr. Takamura is a former professor of gerontology in the School of Social Work of the University of Hawaii. She holds a doctorate from Brandeis University and a master of social work from the University of Hawaii. She is on the Board of Directors of the Hawaii Pacific Gerontological Society and has written numerous articles on geriatric social services.

Dr. Takamura has recently been appointed the Director of the Hawaii State Agency on Aging.

Dr. Takamura, I want to welcome you to Washington and thank you for making the long trip here to provide us with your advice and assistance.

Now, Dr. Phelps is Chairman of the Board of Directors of the American Association of Retired Persons. He is widely known as an authority on psychology and aging issues. He holds a doctorate in psychology from the University of Kansas Meninger Clinic.

Dr. Phelps has been Chairman of the Advisory Council of the Kennecare Day Care Center, in Kansas City, and was Director of the Life Enrichment Program for persons 65 and older at Shepard Center, and remains a member of the board. In his capacity as Chairman of AARP, Dr. Phelps leads the Nation's largest organization of Americans age 50 and older, with over 23 million members. I might say that I myself am a member.

The AARP offers educational and community service programs carried out through a national network of volunteers in local chapters, as well as a variety of educational and advocacy programs for older workers, who make up one-fourth of the AARP total membership.

Welcome, Dr. Phelps.

Now, let us begin by asking each witness to make a brief statement. The full text of the written testimony will appear in the record as though delivered in full.

Dr. Takamura, we will be happy to hear from you.

STATEMENT OF DR. JEANETTE TAKAMURA, DIRECTOR, STATE OF HAWAII EXECUTIVE OFFICE ON AGING; AND DR. C. KERMIT PHELPS, CHAIRMAN, AMERICAN ASSOCIATION OF RETIRED PERSONS

Dr. **Takamura**. Mr. Chairman and distinguished members of the Senate Subcommittee on Aging, it is actually a double pleasure for me to be here today. Senator Metzenbaum was at my graduation at Brandeis when I received my doctorate a few years ago.

I will try to keep my comments——

Senator **Metzenbaum**. I got my doctorate from Brandeis easier than yours, I will bet. Mine was just an honorary one. [Laughter.]

Dr. **Takamura**. A number of current needs of our Nation's older adults are similar to those which were compelling a decade ago. Changes in the social, economic and political context within which the aging agenda must be considered has cast a new light upon many of these concerns. I will attempt to abbreviate my comments because I am aware of your need to get to the floor of the Senate.

We in Hawaii have shifted our efforts away from testing areawide model projects conducted in cooperation with model cities programs. We are now working upon the development and implementation of policies and programs and services that address the long-term care and other requirements of Hawaii's older adult population.

I think the previous witness mentioned, and certainly all of you have mentioned in your comments the growth of the older adult population and the extension of human longevity. Let me just say with respect to that, at the State level we have found it necessary to reconceptualize aging as a phenomenon and to understand its multi-dimensional and its multi-disciplinary requirements.

If we look to the future, we can expect issues pertaining to older adults to command even more pronounced attention. Population projections have indicated that a "squaring" of the population pyramid is occurring and will become even more dramatic during the next century.

State units on aging can be expected to attend to, consequently, the old old, women, and Alzheimer's victims. We can also expect that our most urgent policy program and service concerns will probably revolve around long-term care related dilemmas.

Like other State units on aging, the Executive Office on Aging in Hawaii is engaged in planning, program development, and policy formulations for three distinct subpopulations—the young old, the old, and the old old, which in combination span approximately thirty years of life or more.

Older adult employment, preretirement planning, preventive health education, wellness, economic security, homelessness and housing, housing design, literacy, multigenerational programs, the development of a long-term care system and other concerns are in fact of paramount importance.

I hope that you will permit me to comment very, very briefly on the foregoing concerns. First of all, the development of a community based long-term care system: Without a doubt, these needs, that is of the old adults and their care givers, for support services and programs, such as adult day care, adult day health, home health care, chore, and other personal care and respite assistance programs will be absolutely necessary and may be expected to rise considerably in the years ahead.

Let me also mention that the development of coordinated aging data systems which permit the retrieval of usable information for planning, evaluation, policy formulation, and other purposes will also be important, particularly if our future efforts are to be based upon solid evidence and information.

The strengthening and expansion of protective services mechanisms is also something that I would like to underscore. This is essential, in light of rising rates of elder abuse and neglect. I think you are all familiar as well with the need to strengthen and expand particularly the ombudsman program.

Finally, let me say that the aging network in Hawaii and other units on aging are both very much supportive of the comments offered by the National Governors' Association and the National Association of State Units on Aging. In relation to these comments, I will mention three points very briefly:

That our experience suggests that States should be permitted to selectively apply cost-sharing principles to those programs which are funded by the Older Americans Act;

That input received from our aging network does not support changes in the age formula for allotting Older Americans Act funds; and

Finally, that there is widespread agreement that the Older Americans Act must reflect a stronger commitment to the protection of older adults from abuse, neglect, and exploitation, to community based long-term care services, and to the support of family members and others who are providing care to older persons.

Thank you once again for the opportunity to comment upon the changing needs of older Americans as they relate to the reauthorization of the Older Americans Act.

[The prepared statement of Dr. Takamura follows:]

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Statement of

The Executive Office on Aging
Office of the Governor
State of Hawaii

Presented to

The Senate Subcommittee on Aging
Committee on Labor and Human Resources

By

Jeanette Takamura, Ph.D.
Director

March 31, 1987

Mr. Chairman and distinguished members of the Senate Subcommittee on Aging:

Thank you for your invitation to appear before your Subcommittee today to comment on the changing needs of elderly Americans as they relate to the reauthorization of the Older Americans Act. I am Jeanette Takamura, Director of the Executive Office on Aging, Office of the Governor, for the State of Hawaii.

With its enactment in 1965, the Older Americans Act provided the impetus for the development and implementation of a full array of programs and services designed to meet the needs and interests of our older adult population. It ensured that concerns pertinent to our aging population would be on the national agenda through the establishment of a strong and visible single-purpose agency in the Executive Branch of our Federal Government.

Since 1965, Congress has amended the Act eight times and, in the process, has expanded both its scope and authority significantly. Undoubtedly, the 1972 and 1973 Amendments in particular are noteworthy because they established a national nutrition program and authorized the development of comprehensive services, area agencies on aging, multipurpose senior centers, and other aging programs and services. The 1973

Amendments have been credited with providing the legislative mandate which facilitated the emergence and growth of a far reaching and vigorous aging network.

While a number of the current needs of our nation's older adults are similar to those which were compelling a decade ago, changes in the social, economic, and political context within which the aging agenda must be considered have cast a new light upon many of these concerns. This is not to say that we are without newly emerging or changing needs. Within the last several years, a number of factors, ranging from a growing awareness of the ongoing aging demographic revolution to the organizational maturity of the aging network, have called our attention to many of these emergent and changing needs. Thus, we in Hawaii have shifted our efforts away, for example, from the testing of areawide model projects conducted in collaboration with Model Cities Programs. Our efforts now are aimed at the development and implementation of policies, programs, and services that address the long term care and other requirements of Hawaii's older adult population, which has an average longevity span that is the best in the nation and is among the very best in the world.

Factors Which Shape Continuing and Emergent Needs

A number of social, economic, and other factors are clearly shaping the continuing and emergent needs of our nation's older adult population. Growth in the number and proportion of older people and the concomittant extension of human longevity have resulted in the significant expansion of the "old old" (85+) population. In this context, "aging" and "long term care" have taken on new meanings, as has the reconceptualization of our older adult population as constituted of "young old," "old," and "old old" persons. At the level of the individual and the family, the sheer demographics of aging have suggested a shift in needs experienced by older adults and their families and have given rise to a host of relatively new pressing concerns such as caregiving and elder abuse. At the level of state government, it has called forth the need to recontextualize aging as a phenomenon and to understand its multidimensional, multidisciplinary requirements.

Many other social and demographic factors have held definite ramifications for our older adult population. Some of these include the growth of female labor force participation, although limited advancement opportunities and comparatively lower salaries and wages have not removed the threat of poverty for women as a group. And, despite the fact that fewer older adults appear to be poor today, one out of eight or nearly 3.5 million still fall below the official poverty line, with almost three-fourths of the elderly poor being women. Changes in the economy, shifting manpower requirements, and improvements in communications and transportation technologies have been among the factors which have led to increased geographic mobility. Possibly because of changes such as this, multigenerational households appear to be less numerous, and 30% or 8 million of all persons 65 years of age and older now live alone, 75% of them in their own homes, but a growing number in costly rental units from which their displacement has become a more common occurrence. Estimates suggest that 15-20% of the homeless in America are older persons who are 60 years of age and older.

If we look to the future, it seems clear that we can expect issues pertaining to older adults to command even more pronounced attention. Population projections have indicated that a "squaring" of the population pyramid is occurring and will become even more dramatic through the next century. Anticipating this, it is inevitable that state units on aging will be responsible for a greatly expanded number of older persons who will represent sizeable proportions of the general population. We can expect that the old old, women, and Alzheimer's victims will require more assistance and that the most urgent policy, program, and service concerns will probably revolve around long term care related dilemmas.

State Policy, Program, and Service Agendas

At the State level, demographic realities have shaped our policy and program agendas in real terms. The priorities of the Executive Office on Aging in Hawaii, for example, necessarily attend to the anticipated growth of the state's 65+ group by more than 90% in the next two decades, as compared to a 30% increase in the total population during the same period, and also to the rapid increase which is expected in the proportion of the 85+ population in the islands by the turn of the century. Like other State units on Aging, the Executive Office on Aging is thus engaged in planning, program development, and policy formulation for three distinct subpopulations -- the young old, old, and old old -- which in combination span approximately thirty years of life or more.

While efforts at the State level were focused upon the development of the aging network at the start of the last decade, current policy, program, and service development activities are aimed at addressing the diverse needs of the heterogeneous older adult population, with particular attention to concerns related to the long term care of our fragile, and often oldest elders. Older adult employment, preretirement planning, preventive health education, wellness, economic security, homelessness and housing, literacy, multigenerational programs, the development of a community based care system and of component programs and services, the establishment of comprehensive aging data systems, protective services, the special needs of those afflicted with Alzheimer's or who have developmental disabilities, caregiver needs, education and training programs for those who are engaged in work with older adults, and the special needs of older women, minority group members, and persons who reside in rural communities or are isolated may be listed as some of the concerns which now face the Hawaii's Executive Office on Aging and other state units on aging.

While all of the foregoing concerns are important, permit me to comment on several of them:

- The development of a community-based long term care system and of component programs and services.

  Almost three-fourths of all informal help received by older people is provided by family members or friends. Nonetheless, geographic mobility, higher rates of female labor force participation, reduction in family size, and the desire on the part of older adults to remain self-sufficient and in familiar surroundings mean that traditional caregiving assumptions and arrangements are often strained. With increasing incidence, family members who wish to be involved in caregiving are finding themselves in need of supportive services and programs such as adult day care, adult day health, home health care, chore, and other personal care and respite assistance. These needs may be expected to rise considerably in the years ahead, given the mound of evidence which indicates that more young old and old persons are serving as caregivers to the old old and that the incidence of Alzheimer's and related disorders increases markedly with advanced age.

-The development of coordinated aging data systems which permit the retrieval of useable information for planning, evaluation, policy formulation, and other purposes.

Concomittant to the support of essential programs and services for the older adult population must be the development of comprehensive aging data systems which permit the retrieval of usable information for planning, evaluation, policy formulation, and other purposes on a statewide basis. Incentives must be given to agencies and programs to examine existing data bases and to collaborate in the development of coordinated data systems. If such collaboration does not occur, these agencies and programs will continue to gather and generate data which can not be aggregated or compared by the aging network on a statewide basis.

-The development and expansion of protective services mecnanisms.

The development and expansion of protective services mechanisms, including the ombudsman program, is necessary in light of rising rates of elder abuse and neglect. The expansion of community-based long term care is inevitable in light of the fact that it is generally less costly and that such care tends to be preferred by older adults. Older adult consumers of community-based services should be given the same adequacy of care guarantees which patients in long term care facilities are offered through the ombudsman program.

Other Comments Pertinent to the Reauthorization of the Older Americans Act

In addition to the recommendations suggested in the preceding discussion, we are in support of the recommendations which have been offered by the National Governor's Association and the National Association of State Units on Aging. May we note moreover:

- that our experience suggests that states should be permitted to selectively apply cost-sharing principles to those programs which are funded by the Older Americans Act.

- that input received from our aging network does not support changes in the age formula for allotting Older Americans Act funds.

- that there is widespread agreement that the Older Americans Act must reflect a stronger commitment to the protection of older adults from abuse, neglect, and exploitation; to community based long term care services; and to the support of family members and others who are providing care to older persons.

Thank you once again for the opportunity to comment upon the changing needs of older Americans as they relate to the reauthorization of the Older Americans Act.

Senator MATSUNAGA. Thank you very much, Dr. Takamura.

We will be happy now to hear from you, Dr. Phelps. You may proceed, Dr. Phelps. Welcome to the Committee.

Dr. PHELPS. Thank you very much.

Members of the Committee and ladies and gentlemen, on behalf of the Association, I would like to outline some trends in aging in America and share with you some of our recommendations regarding the reauthorization of the Older Americans Act.

The Act has been the only Federal social and community service statute designed exclusively for older persons. In order to foster maximum independence, the mission of the Act has been to provide a range of services to those older persons with the greatest economic and social needs.

As Congress deliberates the reauthorization, it is important for the aging community and policy-makers to consider demographic and social changes in the aging population, and this will provide a framework for policy recommendations on the immediate and future needs of older persons.

I think everyone is aware of the rapid growth in the Nation's older population. By 1980, the number of persons 55 and over increased by 141 percent, and those 65 and over by 183 percent. By the year 2035, every fifth American will be 65 years of age and over.

As the older population has increased, there has been a substantial shift in the sex and racial compositions. Older women now outnumber men three-to-two. By 1990, 11.3 million women 65 and older will be single and living alone, compared to the 8 million today. These changes will have a great impact on the demand for income supports, social services, and health care.

Although older minorities will continue to comprise a smaller group in absolute numbers than older whites, their numbers are increasing at a faster rate than the older white persons. Major changes in public policy are essential to cope with the trends in aging.

Today, there are about 20 persons 65 years and over for every 100 persons of working age, and after the baby boomers turn 65 around 2030, however, this ratio is expected to double. Such changes will have a significant impact on the provision of adequate housing, health and social services, employment and social security, since there will be fewer workers to support publicly funded programs for older persons.

The Older Americans Act program can respond to the needs of this changing older population in a variety of ways. First, health and long-term care; second, income maintenance; third, housing; fourth, social services; and last, the extension of the Older Americans Act and heightened visibility of the Administration on Aging, AARP strongly believes that the legislation should be extended for at least three years.

We strongly believe that the aging agenda should be elevated within HHS by having the Commissioner report directly to the Secretary, rather than to the Office of the Secretary.

To maximize the benefits derived from each OAA dollar, AAA should be required to reaffirm their commitment to a coordination, facilitation advocacy role. Sometimes AAAs have to assume the role of service providers, but the use of OAA funds for service delivery should not take priority over the coordination mandate of the Act.

AARP opposes consolidating funds for OAA programs with funds for other programs within the Office of Human Development Services. Further, the association opposes consolidating funds of different programs under the same titles within the Older Americans Act.

An allotment formula is used in computing the amount of Federal money each State will receive under the OAA. Any proposal to raise the population threshold for the allotment of funds under section 303 from age 60 to 70 should consider the service needs of special populations such as minorities, frail elderly persons, and the rural elderly poor who do not meet the arbitrary age threshold for the allocation of funds.

Our concern should focus not only on those who manage to survive to age 70, but to assure that as many as possible live as long as possible.

The association believes that the current allocation formula has served its usefulness. AARP continues to support a policy of voluntary contributions for service. We recommend that no broad fee for service plan be adopted prior to carefully monitored demonstrations where the impact on minorities and low-income elderly populations can be ascertained.

Due to lower minority participation rates in OAA programs, the association urges that stronger statutory language be used to promote participation.

AARP believes that legal services for older persons should be reauthorized as a priority service under the Older Americans Act.

Senator **Matsunaga**. Dr. Phelps, we have a vote on the floor now proceeding. Could you finish up in a minute?

Dr. **Phelps**. In less than a minute.

Senator **Matsunaga**. Thank you.

Dr. **Phelps**. Mr. Chairman, because of time constraints, I would like to refer the Committee to the association's other recommendations in our written statement.

In conclusion, AARP urges prompt reauthorization of the Older Americans Act. Our suggested changes to the Act and its administration require little statutory change, but greatly improve services for all other Americans. The elderly of our Nation deserve our most careful attention to this important legislation.

Thank you very much.

[The prepared statement of Dr. Phelps follows:]

AARP

TESTIMONY

OF

DR. KERMIT C. PHELPS, CHAIRMAN
AARP BOARD OF DIRETORS

ON BEHALF OF

THE AMERICAN ASSOCIATION OF RETIRED PERSONS

BEFORE THE

U.S. SENATE COMMITTEE ON LABOR & HUMAN RESOURCES

SUBCOMMITTEE ON AGING

REGARDING

REAUTHORIZATION OF THE OLDER AMERICANS ACT

MARCH 31, 1987

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EXECUTIVE SUMMARY

The Association strongly supports the Older Americans Act (OAA). It should continue to target services to special populations while providing sufficient flexibility to state and local agencies to meet local needs.

AARP believes the legislation should be extended for at least three years, and authorized at such sums as necessary. The Commissioner should report directly to the Secretary rather than to the Office of the Secretary.

Sometimes AAAs have to assume the role of service providers, but use of OAA funds for service delivery should not take priority over the coordination mandate of the Act. AAAs should be involved in case or care management only as part of a carefully controlled demonstration that includes a broad array of other non-profit entities besides AAAs.

AARP opposes consolidating funding for OAA programs with funds for other programs within the Office of Human Development Services. Further, the Association opposes consolidating funds of different programs under the same Title within the Older Americans Act.

Any proposal to raise the population threshold for allotment of funds under Section 303 from age 60 to 70 should take into account the service needs of such under 70 groups as older minorities, frail elderly persons, and the rural poor. The Association also urges that stronger language should be incorporated in Title III to promote increased participation by aged minorities.

Legal services for older persons should be reauthorized as a priority service under the Older Americans Act with a requirement that at least 6% of Title III (B) money be spent on each priority service. Congress should also authorize a private right of action for procedural violations of the Act, a study to determine compliance with priority service requirements, and reauthorize Section 424 of the Act.

The Association recommends that no national fee-for-service plan be adopted prior to a carefully monitored demonstration being implemented and evaluated to determine impact on the neediest older populations.

Service to older Indians under Title II should be more accessible. Similarly the Administration on Aging and the Labor Department should devise a more effective strategy for meeting the enormous employment needs of older Native Americans.

The increased number of individuals receiving institutional care necessitates an expansion of the role of the Ombudsman to permit more effective monitoring and advocacy on behalf of older persons. AARP opposes an extension of Ombudsman authority into home health care services at this time. However, the Association does endorse authorization of specialized centers for long term care research, education, and training.

AARP supports reinstatement of the 15% administrative cap for national sponsors of Title V senior employment programs to encourage job development, increase unsubsidized placements, and prevent termination of program enrollees.

The Association also supports statutory changes that encourage coordination of the Older Americans Act programs with programs administered by other agencies, especially programs for the disabled and American veterans.

The Association further recommends that a 1991 White House conference on Aging be held with a single unifying theme to focus attention on the more critical issues of aging trends in America.

TESTIMONY OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS REGARDING REAUTHORIZATION OF THE OLDER AMERICANS ACT
PRESENTED BY DR. KERMIT C. PHELPS

Good afternoon Mr. Chairman, Members of the Committee, ladies and gentlemen.

I am Dr. Kermit C. Phelps, Chairman of the Board of the American Association of Retired Persons. On behalf of the Association's more than 24 million members I would like to outline some trends in aging in America, and share with you some of our recommendations regarding reauthorization of the Older Americans Act.

For over twenty years, the Older Americans Act has served as the sole federal social and community service statute designed exclusively for older persons. In order to foster maximum independence, the mission of the Act has been to provide a range of services to those older persons with the greatest economic and social need. As Congress deliberates the many issues of reauthorization under the Act, it is important for the aging community and policy makers to consider demographic and social trends in aging. This will allow us to frame our policy recommendations not just around immediate needs, but also the needs of older persons in the future.

Size and Growth of the Older Population

Everyone is aware of the rapid growth in the nation's older population. What is startling about the aging trend today is the rapid pace. In the last two decades alone, the 65 and over population grew by 54 percent while the under 65 population increased by only 24 percent. In 1940 there were just over 20 million persons 55 years of age or older and about 9 million over age of 65. By 1980, the number of persons 55 and over increased by 141 percent and those 65 and over by 183 percent.

Increases in these two populations pale when compared to increases in the oldest age groups, those 75 and over. The number of persons 75 and over has increased by more than 275 percent between 1940 and 1980. This trend is expected to continue into the next century. By the year 2035 every fifth American will be 65 years of age and over.

As the older population has increased, there has been a substantial shift in its sex and racial composition. Since 1940, women 55 and over constitute a greater proportion of the older population. The survival rate for women at age 65 is 30 percent greater than men of the same age. As a result, older women now outnumber men three to two. Census projections indicate that by 1990 there will be 11.3 million women 65 and older who will be single and living alone, compared to approximately 8 million today. These changes will have a great impact on the demand for income supports, social services, and health care.

The increase in the number of older minorities has also contributed to the significant growth in the older population. The number of older persons who are members of minority groups has increased faster than the number of older white persons. By the year 2025, the portion of older persons who are minorities is projected to increase 75 percent compared to a 62 percent increase for the white population. Older minorities, however, will continue to comprise a smaller group in absolute numbers than older whites.

Major changes in public policy will be essential to coping with the effects of the changing numbers in different age groups. Presently, there are about twenty persons 65 years and over for every hundred persons of working age. After baby-boomers turn 65 around the year 2030, however, this ratio is expected to double. Such variations in the dependency ratio will have a significant impact on the provision of adequate housing, health and social services, employment, and social security due to the decline in the number of workers to support such publicly-funded programs for older persons.

The Older Americans Act program can respond to the needs of this changing older population in a variety of ways:

o Health and Long Term Care

As the incidence of frailty, disability, and chronic illness increases in a growing older population, the OAA can play an important role in the development of a comprehensive coordinated system of health and long term care services. While most older persons are somewhat healthy and active in their early retirement years, health and mobility decline with age. Important issues for the future will have to focus on health service needs and cost containment, including services designed to help older persons function within their own homes.

The problems associated with rising health care costs will continue perhaps beyond this century. As this occurs, we need to pay equal attention to access and quality of health and medical care.

o Income Maintenance

The provision of adequate income for older Americans is one of our greatest challenges. An adequately funded and expanded Title V program is essential to meet the employment needs of older Americans. While there is a growing perception that the economic status of older persons has improved significantly, when the cash income of the elderly is compared to that of the young working population, there remains a substantial discrepancy. While the proportion of elderly poor has dropped by two-thirds since 1959, our future concern must focus on how to meet the public costs of income maintenance for older persons given the increased older population, expanded longevity, and inflation. In order to stretch limited resources we must continue to focus on building public and private program structures that increase retirement income opportunities, particularly those serving older persons with lower incomes.

o Housing

Few issues will be more important to the future well-being of older people than their living environments. Adequate supportive service programs under the Older Americans Act such as homemaker, friendly visitor, and chore services are essential to prevent premature institutionalization of many older persons. Expanding and strengthening such services will be essential to a properly designed housing policy in the future and may contribute in saving public resources expended on older persons. Current demographic projections indicate that the number of households headed by older persons is steadily increasing. More than one-fifth of all U.S. households are headed by persons 65 and over and this figure will rise by 33 percent in 1995. As the proportion of older persons increases, particularly the frail elderly, the dominant issue will be how can we design and implement interventions to assist older persons in coping with their housing and independent living needs.

o Social Services

Much of our success in meeting the future needs of our older population will lie in our ability and willingness to strengthen provisions under the Older Americans Act. As funding for social service programs declines in the face of increasing demand, the Older Americans Act, as the focal point for federal assistance to older persons, becomes even more critical. The present system is plagued by fragmentation, duplication, and ineffective coordination efforts at all levels. Increasing life expectancy will have major implications for the way we must revamp our human service delivery systems. Coordination will be critical if we are to adequately address the needs of older persons in extremely varied circumstances and with varying levels of need. This means that the Act should continue to target services to special populations while providing sufficient flexibility to state and local agencies to meet local needs.

The following are some of our specific recommendations that directly affect the most vulnerable and disadvantaged elderly persons. AARP believes these needed improvements in the Act would facilitate better service to all of the nation's elderly population.

Extension of the Older Americans Act and Heightened Visibility of the Administration on Aging

AARP strongly believes that the legislation should be extended for at least three years. This would enable service providers and others to make long-range plans and to chart their activities more effectively. Morever, it would still allow appropriate congressional committees to perform oversight responsibilities. Also, because many programs have operated with no increased funding or cuts, AARP will continue to advocate adequate funding for all programs under the Act, especially those targeted to vulnerable populations. This could be achieved through authorization of such sums as necessary.

The Older Americans Act and subsequent amendments make clear that Congress intended the Administration on Aging (AoA) to be a highly visible and strong advocate for the aged. However, AoA is currently a subunit along with several other agencies (such as the Administration on Children, Youth, and Families or the Administration on Developmental Disabilities), within the Office of Human Development Services at the Department of Health and Human Services (HHS).

The net impact is that AoA has not fulfilled its intended role because of its lower status in the HHS organizational structure. We strongly believe that the aging agenda should be elevated within HHS by having the Commissioner report directly to the Secretary rather than to the Office of the Secretary.

Advocacy, Coordination, Facilitation, and Care Management Roles of Area Agencies on Aging (AAAs).

The role of Area Agencies on Aging (AAAs) as service providers by contrast to their role as facilitators/coordinators and advocates is a major concern of the Association. Congress recognized when the law was enacted that there would always be insufficient funds under the OAA to serve all eligible elderly persons. In order to maximize the benefit derived from each OAA dollar, AAAs should be required to reaffirm their commitment to a coordination/facilitation/advocacy role. The current requirement to justify direct provision of services to older persons in the state plan needs stronger emphasis, and more attention needs to be placed on coordination, facilitation and referral. Although there may be a need in some situations for AAAs to assume the role of service providers, use of OAA funds for service delivery should not take priority over the ability of AAAs to perform the coordination mandate of the Act.

AAA involvement in case or care management should be considered only in the context of the above comments and recommendations. Additionally, it should be noted that in situations where the AAAs become the direct deliverers of service, there is great potential for conflict of interest between their marketplace provider role and their statutory role to facilitate, monitor, and advocate.

In light of these concerns, it seems appropriate that AAAs be involved in case or care management only as part of a carefully controlled demonstration that includes a broad array of other non-profit entities besides AAAs. The exception would be where other providers (private and non-profit) are not responding to the need for services.

The demonstration sites should be selected on a competitive basis. Each demonstration applicant should submit a plan for activities and intended outcome. Periodic evaluation of plan implementation and outcomes would be required. Demonstration costs should not exceed a specified reasonable amount.

Opposition to Consolidation of Funding for OAA Programs

AARP opposes consolidating funding for OAA programs with funds for other programs within the Office of Human Development Services. Further, the Association opposes consolidating funds of different programs under the same Titles within the Older Americans Act. For example, we favor separate authorizations for (1) supportive services and senior centers, (2) congregate meals, and (3) home-delivered meals. We fully recognize that a single authorization would make it easier for state and local offices on aging to submit funding plans. It would also provide great flexibility for offices on aging. However, these "administrative convenience" arguments are outweighed by other considerations. First, separate authorizations for supportive services, congregate meals, and home-delivered meals enable these programs to maintain greater visibility. This, in turn, has produced more realistic appropriations, especially for the nutrition program.

Second, there is already flexibility to shift funds under Title III. For example, 30 percent of the funding for the nutrition program for the elderly can be transferred to supportive services and senior centers, and vice versa. Moreover, up to 15 percent of the nutrition appropriations can now be shifted between congregate meals and home-delivered meals. AoA approval is required if a larger percentage is needed. In fact, there has already been a significant transfer of Title III funds.

Third, consolidation of OAA program funds with other OHDS monies or consolidation of program funds under the Act itself makes services to older persons more vulnerable to a block grant. This would certainly mean less funding to services for older Americans, and especially aged minorities. For example, before elimination, only a tiny fraction of revenue sharing funds were used for services for the elderly. In addition, block-granting is usually a prelude to program cuts. With ever increasing numbers of older persons, cuts could not be more ill-timed.

Redesignation of Planning & Service Areas

In order to avoid jurisdictional disputes and possible service disruptions, AARP questions the advisability of any proposal to expand the authority of AoA and the states to redesignate planning and service areas. Ample authority already exists to change planning and service area boundaries when necessary.

Opposition to Raising the Age for Allocation of Funds Without Taking into Account the Needs of Special Populations

An allotment formula is used in computing the amount of federal money each state will receive under the OAA. Any proposal to raise the population threshold for allotment of funds under Section 303 from age 60 to age 70 should take into account the service needs of special populations (such as minorities, frail elderly persons, and the rural elderly poor) who do not meet the arbitrary age threshold for the allocation of funds. A formula change which targets additional funds to states with higher concentrations of persons over 70 as proposed by the Administration, may be justified because of the increased costs in serving this group. However, the Administration's proposal, unless modified, would set a dangerous precedent for ignoring the real health, nutritional, and social needs of those in their sixties who are presently served. Not only does this create an inconsistency by having a formula based on 70 when the program serves persons at age 60, it ignores the special needs of minorities who depend more upon services to the elderly between ages 60 and 70 and statistically do not have a 70-year life expectancy. Although those minorities reaching age 70 typically live as long as the general population, inadequate health and other factors in earlier years contribute to lower life expectancies. Our concern should focus not only on those who manage to survive to age 70, but to assure that as many as possible live as long as possible. Indeed, need for service should be the factor weighted most heavily in any effort to revise the allocation formula.

The Association believes that the current formula for allocation has served its usefulness and we should begin exploring new alternatives that reflect future realities of aging. A more effective allocation formula would weigh four criteria. Highest weight would be assigned to economic need, followed by social need (minority and age 75+), then rural, and finally those over age 60. Such a formula should be phased in over the length of the next reauthorization of the Act and should include a hold harmless clause for funding to states. This would ensure that no state suffers cuts but redirects any new funds to areas of need. Intra-state allocations should also reflect this formula change.

Finally, 35 states would lose money under the age 70 based formula until 1991 when most are expected to approach or slightly exceed current funding levels. Given the demand, our emphasis should be to reverse this negative association between funding and growing need.

Fee-For-Service Under the Older Americans Act

The proposal that states and AAA's be given the option to set sliding scale fees for service raises concern about the following:

(1) voluntary contributions or mandatory payment for services;

(2) payment based on income; and
(3) adequacy of current cost sharing contributions mechanisms.

AARP has traditionally supported voluntary contributions emphasizing non-aggressive solicitation of contributions from those who could afford to pay. State and area agencies believe that a sliding scale fee would permit coordinating OAA program services with other services that are means-tested in some way. There would be no fee for referrals, outreach, advocacy and Ombudsman services. What is not clear is which services (e.g., health, transportation, homemaker, legal, meals, chore on companion) would be subject to contributions and how the rates would be set. There should be protected groups that would be exempt from fees such as those with incomes less than 125% of the poverty standard. Unfortunately, some evidence suggests that declining participation by minority and low income populations results from a perception that a voluntary contribution is actually a charge for service.

AARP continues to support a policy of voluntary contributions for service. We recommend that no broad fee-for-service plan be adopted prior to a carefully monitored demonstration where the impact on minorities and low income elderly populations can be ascertained. In such a broad, multi-state demonstration, emphasis should be placed upon non-aggressive solicitations, self-reporting of income, and no direct or indirect coercion. Solicitations for contributions should occur after the service is rendered, and consideration should be given to exempting the contributions requirement altogether for legal services. Even then there should be uniformity among the states as to which services are exempt from contribution, although states should have the option to charge a fee for nonexempt services. Only after we have devised ways to ensure fair fees that do not deter those most in need should the policy be expanded to a national one.

Minority Participation under the OAA

Due to the dramatic decrease in minority participation rates in OAA programs, the Association urges that stronger statutory language should be incorporated in Title III to promote increased participation by aged minorities in services programs. Older minorities receive about 18 percent of services under Title III of the Act. But their participation rate is nearly twice that level in the Title V Senior Community Service Employment Program (SCSEP). In fact, minorities constitute about 40 percent of all Title V enrollees. Minority participation rates under Title III have declined every year except one from FY 1980 to FY 1985.

Findings of the 1982 Minority Elderly Services Report by the U.S. Civil Rights Commission concluded that while older minorities participated to some extent in all Title III programs, there were some services where minorities were consistently absent. Minority persons often felt that OAA programs were not responsive to their needs and priorities; meals were not culturally appropriate; non-English publications were seldom available; and there was insufficient publicity about OAA programs and referral services. Outreach to minority older persons by AAAs was poor, and minorities were absent or excluded from the service delivery planning process on local advisory councils. A final reason for lower minority participation was the failure of state offices on aging to monitor the civil rights compliance of local offices on aging. The Commission report noted underrepresentation of minority contractors under Title III and low status for minorities working in AAAs.

AARP believes that the OAA should require state plans to include reasonable assessments of aging minority needs. Moreover, they should be served on the basis of their need for service rather than their proportion of the overall population. State Units on Aging and AAAs should engage in appropriate outreach efforts to include liaison with community organizations concerned with the needs of minority elderly persons. Additionally, the Association urges that the OAA should require federal, state, and local offices on aging to take affirmative steps to promote opportunities for minority employment, training, and contracts. The aging services network, we firmly believe, will be more effective in responding to the special problems and challenges confronting older minorities if more minorities are employed in decision-making positions and as service providers. More bilingual personnel should be hired to serve limited-English-speaking older persons.

Documentation of efforts to serve older minorities should also be required. The Commissioner should be given the discretion to withhold some reasonable sum from the state where it consistently fails to meet modest goals outlined in the state plans on service to elderly minorities. The Commissioner would then contract for services to targeted minorities or authorize the state to contract for such services.

Finally, it is essential to encourage more minorities to enter the field of aging because there is a dearth of adequately trained minority professionals and para-professionals in gerontology.

Legal Services Under the Older Americans Act

Older persons not only have the same legal service requirements as most other Americans, but also have additional need for legal services due to their unique health, income, and social status. Older people are often dependent upon services provided by large government bureaucracies using complex and often changing regulations, guidelines, and procedures. Affordable, competent legal assistance is critical to their ability to obtain basic necessities such as health care, in-home support services, protective services, or other benefits. Legal problems of elderly persons may also relate to discrimination in the workplace, a landlord-tenant controversy, or other disputes which may require judicial intervention.

AARP believes that legal services for older persons should be reauthorized as a priority service under the Older Americans Act. Because many AAAs provide little or no legal services to older persons, the law should be amended to require at least 6 percent of the funds appropriated under Title III (B) to planning and service areas be expended for each priority service. The establishment of at least 6% of Title III (B) money would restore legal services funding to its FY 1980 level. However, maintenance of effort language is necessary for programs currently spending more than 6 percent. It should be clear that 6% is not to be interpreted as a ceiling.

The Congress should also authorize a private right of action for procedural violations of the Act. This private right of action should extend to both service providers as well as program beneficiaries.

Under the current law, violations of the Act cannot be redressed in court since the courts have held that there is no implied cause of action or standing for affected parties. Without the ability to sue in court, an older person has no effective redress when, for example, an area agency illegally charges for meals under the Title III nutrition program, or fails to provide legal assistance within its planning and service area. Similarly, without standing in court, a legal services provider cannot sue a state for its failure to provide an administrative hearing in a situation where a local area agency had failed to provide legal assistance in its jurisdiction.

AARP further recommends authorization of a study to determine compliance with priority service requirements. The Secretary of the Department of Health and Human Services must enforce the Act with regard to priority services. In 1975, Congress authorized a study to examine the effectiveness of prioritizing services under the Act. The study revealed that prioritization did focus more money upon access, support, and legal services, but that legal services remained least favored among the three programs.

The Association supports Reauthorization and funding of Section 424 of the Act which authorizes national legal services support and demonstration projects operated by national non-profit legal assistance organizations. AARP further recommends a separate authorization of $1 million for the the work of national legal assistance organizations mentioned in 424 (a)(1) of the Act. Also the scope of 424 (a)(1) services should be expanded to serve legal assistance providers as well as state and area agencies.

National Legal Services support centers (such as the National Senior Citizens Law Center) provide training, support, and backup to lawyers who represent older clients. Assistance ranges from case consultation and legal advice to the development of training materials and programs for lawyers and paralegals.

Better Coordination of Services to Native Americans and Indians

AARP recommends that older Native Americans should also be served under Title III when such services are not duplicated under Title VI. It is vital for older Indians and other Native Americans to receive services under the Act through whatever mechanisms most efficiently meet their legitimate needs. Any view that Title VI, because it is targeted exclusively to Indians, should be the sole source of service to elderly Native Americans overlooks the needs of those off reservations who cannot be reached by tribal services. This proposal would also eliminate inequities resulting from overlap and administrative complications between Titles III and VI under the Act.

Strengthening the Ombudsman Program:

Ombudsmen play critical roles as consumer advocates for the nation's 1.5 million nursing home residents. Although there are ombudsman programs in every state and territory, their effectiveness varies widely. AARP believes that increased federal funding and stronger federal leadership is necessary to ensure the efficacy of this important program.

A number of changes are necessary to strengthen ombudsmen's direct roles in consumer protection. Not only state ombudsmen but their designees, such as local and volunteer ombudsmen, should be granted 24 hour access to nursing home and board and care facilities. With the approval of the resident or his/her representative, they would have the same access to residents and their records. Reprisals against residents or employees who file complaints should be strictly prohibited. Further, legal representation should be authorized for ombudsman programs and for ombudsmen who are the subject of legal action as a result of "good faith" effort to do their jobs. The federal government also needs to provide strong support for the establishment of ombudsman training and technical assistance programs at state and substate levels.

In addition to aiding individual residents, ombudsmen can be important conduits of information to regulatory agencies and to public officials. Mechanisms should be developed to ensure that state licensing and certification agencies (and where appropriate, PROs) consider data on problems of quality identified by ombudsmen. They would also share with ombudsmen such information.

The Older Americans Act makes ombudsmen responsible for advising public officials on the effects of laws and regulations on nursing home residents. This responsibility, however, can be interpreted as conflicting with OMB circular A-122 which prohibits federally funded programs from lobbying. Ombudsmen, including substate ombudsmen, should be exempted from the anti-lobbying provisions of this circular.

AARP opposes an extension of ombudsman authority into home health care services at this time. Ombudsmen have indicated that they do not have the resources to undertake an effective monitoring and advocacy role in this area. An extension of ombudsman authority into home care would jeopardize current work in nursing homes, as well as the expansion into board and care facilities that was authorized in 1981 but remains almost entirely unfulfilled.

Finally, a study on mechanisms to ensure the quality of care in nursing home, board and care, and home health settings should be undertaken. It should include, but not be limited to, representatives of consumers, providers, the Congress, HCFA, the Administration on Aging, and the AAAs. The study should include an analysis of quality control methods used in similar settings, i.e., those used with the mentally retarded/developmentally disabled.

Specialized Long Term Care Research, Education, and Training Centers

Our nation needs to build a much stronger base for research, education and training on community-based long-term care. As a step in that direction, AARP supports the authorization of funding under Title IV for up to 10 such specialized centers. The centers would be funded on a competitive basis for 5 year intervals. Centers would be evaluated yearly. Reapplication would be encouraged where evaluations show effective, innovative, and efficient operation. This would prevent costly and harmful service interruptions while assuring that effective performance is recognized. We envision at least the following criteria in the implementation process:

A. Applicants would include such entities as institutions of higher education, public agencies such as State Offices on Aging and AAA's, and non-profit organizations.

B. The centers would be focused topically, not by region, to support the development of comprehensive, coordinated community-based service systems and service delivery methods (including family support), to provide training and technical assistance in such methods, to support community education on long term care, to engage in research, education and training in close collaboration with community agencies including, but not limited to, agencies funded under the Older Americans Act. Center activity should focus on services designed to support alternatives to institutionalized living and the assessment of need, the development and coordination of plans of care, linkage among institutional (including hospital) and non-institutional providers, and family support.

C. Center activities should emphasize interdisciplinary and intergenerational approaches to service delivery and training and should include projects addressing the needs of special populations, including but not limited to the indigent, the oldest old, persons with Alzlheimer's disease and related disorders, the disabled persons, minorities, and rural elders.

Coordination of OAA with Programs for the Disabled and American Veterans

The elderly population is extremely diverse and has problems that are addressed by a broad array of federal and state agencies and programs. Frequently programs and agency administrators fail to maximize their effort on behalf of their client population due to lack of coordination. Two such areas of insufficient coordination on behalf of older persons by the aging network are veterans and the disabled. The Association supports coordination of services between programs under the Older Americans Act and programs serving veterans and disabled persons. AARP recomends that the Act be amended to reflect this clarification of the law.

Coordination should be encouraged between the aging network and the disability network generally, and should not be limited merely to coordination with the developmental disabilities network. The term "developmentally disabled" refers to mental and communications disorders whose onset occurs prior to adulthood. Therefore, those persons whose disabilities occur late in life would be excluded from the "developmentally disabled" population. We recommend, therefore, that language authorizing coordination of services should be broad enough to include all disabled persons, regardless of when their disabilities occurred.

In light of limited funds under the OAA, we recommend that coordination of services be permissive and not mandatory at this time. Since no one is sure exactly how many otherwise eligible disabled persons would require services under the OAA, we recommend that coordination be authorized initially on a discretionary basis. Similarly, more coordination of programs by AoA and those provided for veterans should be encouraged.

Concerns About Title V

Currently, sponsors under Title V (Community Services Employment for Older Americans) have a 13.5 percent administrative cap. This cap is unreasonably low given the high cost of placing senior workers in unsubsidized jobs. Among National Sponsors, unsubsidized placements is directly correlated with administrative cost. AARP believes that reinstating the 15 percent administrative cap would increase the number of elderly persons placed in unsubsidized employment. It would also help to ensure that national contractors expand job development activities. As a national sponsor, AARP has recently placed 45.5 percent of its enrollees in unsubsidized jobs. This was by far the best performance among national sponsors. However, the lower cap may jeopardize this placement record by forcing consolidation of projects and curtailment of job development acitvities. This could result in loss of employment opportunities for present and potential enrollees.

Another major concern of the Association about Title V is the inadequate level of service to Native Americans. Although Title V targets low income and minority populations, Older Native Americans, with a poverty rate exceeding 60 percent, continue to be the least served population both in terms of numbers and level of need. The Administration on Aging and the Department of Labor should be directed to make a determination of how to best meet the employment and training needs of older Native Americans in a comprehensive strategy. Since certain minority groups are represented by at least one national sponsor under the Act, serious consideration should be given to directing proportionate increases in Title V funding to the creation of a national sponsor for Native Americans.

1991 White House Conference on Aging

In order to focus attention on major issues of importance to older persons, the 1991 White House Conference on Aging should emphasize a unifying theme. This will enable policy makers, the aging community, and the public to better assess the present status of older Americans and to propose comprehensive solutions for the future. AARP endorses the theme "Maintaining Independence" for the 1991 Conference. It would address six areas: economic security; long term care; opportunities for a longer worklife; affordable health care; community building with intergenerational resources; and those left behind who are the most vulnerable populations.

Conclusion

As the aging population grows, greater demands are placed on the social service system. Therefore, an aging network that responds effectively to the needs of older persons is vital. Improved access to existing programs under Title III of the Act; expanded responsibilities of the state ombudsmen in protecting our older citizens in their living environments; improved legal services; better research, training, and demonstrations in the field of aging; and more fiscally responsible coordination and administration of programs serving the elderly should be the priorities of reauthorization.

AARP urges prompt reauthorization of the Older Americans Act. Our suggested changes to the Act and its administration, although requiring little statutory change, will help to greatly improve services for all older Americans. The elderly of our nation deserve our most careful attention to this important legislation.

Senator **Matsunaga**. Thank you very much, Dr. Phelps. I wish to recognize now the presence of Senator Strom Thurmond.

Do you have an opening statement, Senator?

Senator **Thurmond**. Mr. Chairman, I have about a minute and a half.

Mr. Chairman, I wish to commend you for moving forward in reauthorizing the Older Americans Act of 1965. As an original cosponsor of the reauthorization measure, I look forward to working with you in moving this bill through Congress.

Mr. Chairman, the older population now numbers approximately 28.5 million people. They represent 12 percent of the U.S. population—about one in every eight Americans. The number of older Americans has increased by 2.8 million or 11 percent since 1980, compared to an increase of 4 percent for the rest of the population.

Moreover, the older population itself is getting older. In 1985, the 65- to 74-year-old age group was nearly eight times larger than at the turn of the century, the 75- to 84-year-old group was 11 times larger, and the 85 and older group was 22 times larger. Thus, as Americans live longer, we will face new challenges in meeting the needs of the elderly.

Mr. Chairman, I am looking forward to hearing from the witnesses today, and I will read the testimony of those that I missed, while my schedule will not permit me to stay the entire time. I want you to know that I am very interested in this subject and will be glad to cooperate with you in connection with it.

Thank you.

Senator **Matsunaga**. Thank you very much, Senator Thurmond. Without objection, the statements of the members will appear in the record as though presented before the witnesses' testimony.

Senator **Thurmond**. Thank you very much.

Senator **Matsunaga**. We have a few minutes left before we need to go to the floor to vote. Dr. Takamura, given the fact that there are many services authorized under the Older Americans Act, which services are, in your view, the most critical to be supported by Title III funding, and how do you see demands for different kinds of services changing over the next few years.

Dr. **Takamura**. Again, I will attempt to be as brief as possible. I think all of the services and programs provided for under the Older Americans Act are in fact very necessary. Nonetheless, the witnesses so far have spoken to the importance of in-home community-based care. As we look to the expansion of the elderly population, certainly in the case of Hawaii, which has the longest longevity rate in the Nation and also is very competitive with some of the best rates in the world, we are seeing that there is an absolute need for respite care, for adult day care, for day health care, et cetera.

We are also seeing that these services are necessary, because in fact the very old are being taken care of by the young old and the old. Care giving has become an issue of even greater importance in the last several years.

Senator **Matsunaga**. Thank you very much.

Dr. Phelps, I understand that the AARP takes the position that a demonstration program should be conducted to determine the possible effects of cost sharing by older persons on the participation of the neediest populations. Can you suggest a framework for such a demonstration program?

Dr. Phelps. Well, I have the feeling that AARP is not willing to step out and make some kind of a recommendation without some kind of facts to back it up. One of the reasons why we have added a research arm to our organization, called the Public Policy Institute is to try and dispel misperceptions through actual research and provide some firm basis for making these kinds of projections.

The very kind of thing that we are getting at here, for example, seems to be plaguing us at the moment in the need for some kind of long-term insurance. Individuals over 65 who are on social security can be brought down to almost zero financially by a long hospitalization or nursing home care.

It would not be feasible to advocate that cost sharing is the way we should go, without making some kind of a pilot study to see whether it was feasible. Otherwise we would be in the same kind of boat as people in Ohio who subscribed very heavily to the HMO and in two years the HMO was broke because the subscribers were all 65 and over.

Senator Cochran. Mr. Chairman, as we all know, those second bells that just rang mean that we have got to get going to the floor or we will miss this vote on the floor.

Let me join the Chairman in thanking you for helping the Subcommittee by being here today with your testimony. We appreciate your input into this process and we will stay in touch and hope the line of communication will be open between us as we go through the reauthorization process.

We thank you very much.

Dr. Takamura. Thank you.

Senator Matsunaga. The members of the Subcommittee will be given an opportunity to ask you questions in writing and the record will be kept open. I do hope you will be willing to answer questions which may be submitted to you in writing.

Dr. Phelps. Thank you.

Dr. Takamura. Thank you.

Senator Matsunaga. I must apologize to the next panel of witnesses and the panel following, but we will need to recess now until 3:45. So we will be back here at 3:45, and I apologize to the next witnesses.

Thank you. Thank you for your patience. The Subcommittee stands in recess until 3:45 p.m.

[Short recess.]

Senator Matsunaga. The Subcommittee on Aging will come to order.

Our next panel is here to present a slightly different perspective on the need for social services for the elderly.

Ms. Jane Mapp, who is the Director of the Three Rivers, Mississippi Area Agency on Aging, and Mr. Bill Carroll, who is the Director of the Traceway Manor Nursing Home, in Tupelo, Mississippi, are here to discuss a key element of long-term care for the elderly—family care givers.

Senator Cochran, would you like to make any introductory remarks on behalf of your fellow Mississippians?

Senator Cochran. Thank you, Mr. Chairman.

It gives me a great deal of pleasure to be able to welcome two good friends of mine as witnesses for our hearing this afternoon. Ms. Jane Mapp is from Pontotoc, Mississippi, and for the past ten years has served as the Aging Director for the Area Agency in that part of our State. It is the Three Rivers Planning and Development District, and it covers most of the northeastern part of North Mississippi.

She is also a member of the Board of Trustees of the Pontotoc Separate School District. She is a member of the Board of Directors of the Southeastern Association of Area Agencies on Aging.

I am personally acquainted with her outstanding work in North Mississippi and have attended and participated in events there at her invitation, and I know of the excellent job that she has been doing for the elderly citizens of our State. I am glad that she is able to be here today to share some of these observations gained from her experiences with our Committee so that we can do a better job of legislating as we reauthorize the Older Americans Act.

The other member of our panel is from Tupelo, Mississippi, J.W. Carroll. He is an ordained Methodist minister. He has been active in the effort to help provide for the needs of the elderly for the past twenty-two years. He has been active in health planning, he has served on the Governors Health Coordinating Council in our State. He has been an advocate for the older Mississippians in many areas, including religious, civic, and political activities.

He chairs his denomination's Task Force on Older Adult Ministries. He is currently serving as Executive Director of the United Methodist Senior Services of Mississippi, Inc., a nonprofit organization which provides services to more than 3,000 older Mississippians in almost one-half of the State's 82 counties.

As you can tell, Mr. Chairman, he is a leader in this area and from his vantage point and with his experience, I am confident that his testimony will be of great benefit to our Subcommittee in its deliberations, and I am personally grateful to both Mr. Carroll and Ms. Mapp for making the effort to be here today and to participate in this hearing.

Thank you, Mr. Chairman.

Senator **MATSUNAGA**. Thank you very much, Senator Cochran.

We will be happy to hear from you, now, Ms. Mapp.

STATEMENTS OF JANE MAPP, DIRECTOR, THREE RIVERS AREA AGENCY ON AGING, PONTOTOC, MS; AND J.W. CARROLL, DIRECTOR, TRACEWAY MANOR NURSING HOME, TUPELO, MS

Ms. **MAPP**. Thank you, Mr. Chairman. Thank you, Senator Cochran, for the opportunity of allowing me to come visit with you today and share my concerns.

During the ten years that I have been Area Agency on Aging Division Director, I have seen many changes in our aging programs. The emphasis has moved from congregate meal senior centers to in-home services for the frail elderly. And although we feel there still is a place for senior centers, we strongly feel that the formal and informal support systems that allow older people to remain in an environment where they feel most comfortable is of utmost importance.

It is generally accepted that the family care of an older relative is a practice that should be encouraged, but there is a wide range of problems in caring for older persons, and sometimes the care giving role can be overwhelming.

Traditionally, women have been the primary care givers of older relatives. Two changes in the social structure of our country are having a pronounced influence on this. First, the increasing divorce rate has left families fragmented, and, second, the increased proportion of women in the work force.

Many people are caught between the roles of worker, provider, care giver and supporter are understandably frustrated. They feel, and rightfully so, overburdened. The day just is not long enough. It is, however, to this informal support that an older person will turn when in need of help to continue living independently. And whether the person needs a little assistance or a great deal of hands on care, emotional support is nearly always given by family and friends.

The other kinds of support may not be so easy. With more women working, there is not always an adult daughter available for hands on care. Another factor also is the mobility of our society now. There may not always be close family nearby.

We have found that when family members do live some distance away, friends and neighbors are often vital to an older person's well-being and they are the first to notice signs of dependency and are able to alert the family. And while care is always or nearly always given willingly and without question, it is connected to a high level of stress, stress which may be financial as well as physical or emotional.

Surprisingly enough, a small amount of help from the formal support system goes a long way in strengthening the family care giver. We have found that the kinds of help which prove to be most supportive are, one, education concerning the aging process and understanding of what it means to become old and the skills necessary to care for a frail older person can remove fear and uncertainty in care giving situations.

Two, knowledge of available resources: Few people are aware of the programs that exist in their areas, such as Meals on Wheels, homemaker services, volunteer friendly visitor programs, day care, and so on.

Day care centers are especially important when the family members work but need someone to help with the grandmother during the day. These centers provide a variety of activities for those who are able to participate. For those who are unable to be very active, help with medication and blood pressure checks prove to be very helpful at times.

If a person is unable to leave home, the contact with volunteers who bring home-delivery meals is very important. But the most needed and most often requested service is the homemaker program. With a minimum of help once or twice a week, an older person can stay in their own home. Doing laundry, running the vacuum or going to the grocery store, are chores that most people take for granted and accept as second nature. For some older people, these are chores that are insurmountable and that homemaker becomes a trusted friend who makes life easier.

Emergency response systems in our rural areas are very important, too, especially when the nearest neighbor is a mile down the road. We have found that it is extremely difficult to get services to these isolated rural elderly who need them the most. This is mainly because of lack of funds. We have the programs but there are not enough resources to stretch them out that far. Case management is a vital program in that services are brokered from one agency. We feel that anyone should be able to make one phone call to the area agency on aging and be assured of receiving whatever help is available or at least assured that some help will be found somewhere down the road.

Another thing is respite. Care givers are in great need of time each week for their own activities. This will allow them to continue caring. It is also the service that is the least available except on a volunteer basis. And speaking of volunteers, it is important to realize that although we could not function without volunteers, we are asking more and more of them and there are not that many to go around. There are just so many people in each community that can volunteer.

Four is support groups. The formation of support groups of care givers had been found to provide individual recognition and the emotional support required for persons to continue caring. These are sponsored by a lot of different groups, and they have proved to be helpful.

Area agencies on aging are in the business of public education, resource development, coordination of services and advocacy on behalf of the elderly. We spend a lot of time trying to let people know what we are about and what they could do to help. We spend a lot of time developing resources in communities that have an ever diminishing flow of resources. We spend a lot of time trying to get agencies to work together to pool and coordinate those few resources we do have. And we spend a lot of time advocating for the rights of those older people who are one of our Nation's greatest resources in themselves.

We sometimes feel like the care givers who need 36 hour days. We feel that we—and I mean all area agencies—have done a good job in complying with the directives of the Older Americans Act with the limited resources we have been allocated. We have come a long way toward building those community based long-term care systems that are vital to the well-being of our senior citizens.

There is still a lot to do, but with the help and encouragement of the Congress by reauthorizing the Older Americans Act and giving us flexibility in continuing to develop the long-term care systems that will work best in each particular area, we will continue to improve the lot of our older people. We must remember, however, that we cannot continue to meet the needs of the ever-increasing elderly population with the same amount of funds that we have been receiving for several years.

We will continue to work with other agencies to develop that continuum of care. We will continue to work with local governments and the private sector to identify additional resources, and we will continue our advocacy efforts so that not one senior citizen in this great country need feel abandoned. The theme for increasing the visibility of area agencies on aging and aging services is

"Aging America: it's everyone's future." This is most appropriate. We should all keep it and its implications before us constantly.

We appreciate the efforts of this Committee and we especially appreciate again the opportunity to be here. Thank you.

[The prepared statement of Ms. Mapp, with an attachment, follows:]

THREE RIVERS

PLANNING &
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March 31, 1987

Testimony of: Mrs. Jane Mapp, Aging Division Director
Three Rivers Planning & Development District
The Area Agency on Aging
P. O. Drawer B
Pontotoc, MS 38863

Before the Senate Subcommittee on Aging
Spark M. Matsunaga, Chairman
Hart Senate Office Building, Room 404
Washington, D.C. 20510

RESOLUTION

Submitted by: Mississippi Association of Planning & Development Districts,
The Local Area Agencies on Aging

DATE: March 19, 1987

WHEREAS, the Older Americans Act will be considered for reauthorization during 1987; and

WHEREAS, Area Agencies on Aging are mandated to develop comprehensive, community based long-term care systems for the elderly; and

WHEREAS, the elderly in each area of this great Country have different needs; and

WHEREAS, each area has diverse resources and priorities;

NOW THEREFORE BE IT RESOLVED, that the Mississippi Association of Planning & Development Districts, the local Area Agencies on Aging, request that the Congress allow more flexibility in funding programs under the Older Americans Act in order to carry out the intent of this legislation and provide better and more efficient service for the elderly.

Mr. Chairman:

I am Jane Mapp, Aging Division Director for Three Rivers Planning & Development District, the Area Agency on Aging for eight counties in North Mississippi. I have held this position since December of 1976.

During these ten years, I have seen many changes in aging programs. The emphasis has moved from congregate meals - multipurpose senior centers - to in-home services for the frail elderly. And although we feel there is still a place for senior centers, we strongly feel that the formal and informal support systems that allow older people to remain in an environment where they feel most comfortable is of utmost importance.

It is generally accepted that family care of an older relative is a practice that should be encouraged. However, there is a wide range of problems in caring for older persons. And sometimes the caregiving role can be overwhelming.

Traditionally, women have been the primary caregiver of older relatives. Two changes in the social structure of our country are having a pronounced influence on this.

First, the increasing divorce rate has left families fragmented. And second, the increased proportion of women in the workforce has caused us to have to take a second look at this problem of Caregiving.

Many people caught between the roles of worker, provider, caregiver and supporter are understandably frustrated. They feel, and rightfully so, overburdened. The day just isn't long enough.

It is, however, to this informal support that an older person will turn when in need of help to continue living independently.

Whether the person needs a little assistance or a great deal of "hands-on" care, emotional support is nearly always given by family and friends.

The other kinds of support may not be so easy. With more women working, there is not always an adult daughter available for hands-on care. Another factor, also is the mobility of our society now. There may not always be close family available near by.

As people are living healthier and longer lives, an older person is frequently in his eighties before he needs external care. Thus, the adult children who are able to provide care may be themselves close to retirement.

We have found that when family members do live some distance away friends and neighbors are often vital to an older person's well being. They are the first to notice signs of growing dependency and are able to alert the family.

While care is nearly always given willingly and without question, it is connected to a high level of stress. Stress which may be financial as well as physical or emotional.

Surprisingly, a small amount of help from the formal system appears to go a long way in the strengthening of the family caregiver.

We have found that the kinds of help which prove to be the most supportive are:

1. EDUCATION concerning the process of aging. An understanding of what it means to become old and the skills necessary to care for a frail older person can remove fear and uncertainty in caregiving situations.

2. KNOWLEDGE of available community resources. Few people are aware of the programs that exist in their area......meals on wheels, homemaker/home-health aide, volunteer friendly visitor programs, day care, etc.

Day Care Centers are especially important when the family members work but need some help for grandmother during the day. These Centers provide a variety of activities for those who are able to participate. For those who are unable to be very active, services such as help with medication and blood pressure checks are important.

If a person is unable to leave home, the contact with volunteers who bring home delivered meals is very important.

The most needed and the most often requested service is the homemaker program. With a minimum of help once or twice a week, an older person can stay in their own home. Doing laundry, running the vacuum, going to the grocery store are chores that most people accept as second nature but for an older person these tasks may be insurmountable. That homemaker becomes a trusted friend who makes life easier.

An emergency response system is very important, especially in rural areas, when the nearest neighbor is a mile down the road.

We have found that it is extremely difficult to get services to those isolated rural elderly, who need them the most. This is mainly because of lack of funds. We have the programs just not enough resources to allow us to expand to these isolated areas.

Case Management is a vital program in that services are brokered from one agency. We feel that anyone should be able to make one phone call to the Area Agency and be assured of receiving whatever help they need if it is available or at least encouraged that help might be found.

3. RESPITE: Caregivers are in great need of time each week for their own activities. This will allow them to continue caring. It is also the service that is the least available except on a volunteer basis. And speaking of volunteers, it is important to realize that although we could not function without volunteers there are just so many in each community, and we cannot continue to rely on them for more and more. We're to the point now we need additional resources.

4. SUPPORT GROUPS: The formation of support groups of caregivers had been found to provide individual recognition and the emotional support required for persons to continue caring. These are sponsored by community agencies, Churches and self help organizations of caregivers.

Area Agencies on Aging are in the business of public education, resource development, coordination of services and advocacy on behalf of the elderly. We spent a lot of time trying to let people know what we are about and what they can do to help. We spend a lot of time developing resources in communities that have an ever diminishing flow of resources. We spend a lot of time trying to get agencies to work together to pool and coordinate those few resources we do have. And we spend a lot of time advocating for the rights of those older people who are one of our nations greatest resources in themselves.

We sometimes feel like the caregivers who need 36 hour days.

We feel that we, and I mean all Area Agencies on Aging, have done a good job in complying with the directives of the Older Americans Act with the limited resources we have been allocated. We have come a long way toward building those Community based Long-Term care Systems that are vital to the well being of our senior citizens. There is still a lot to do but with the help and encourgement of the Congress by re-authorizing the Older Americans Act and giving us leeway in continuing to develop the long-term care systems that will work best in each particular area, we will continue to improve the lot of our older people. However, we must remember, that we cannot continue to meet the needs of our ever increasing elderly population with the same amount of funds we have been receiving for several years.

We will continue to work with other agencies to develop that continuum of care that ranges from Senior Centers to Nursing Homes.

We will continue to work with local governments and the private sector to identify additional resources.

And we will continue our advocacy efforts so that not one Senior Citizen in this great Country need feel as if they have been abandoned. The theme for increasing the visibility of Area Agencies on Aging and aging services is: "Aging America, it's everyone's future." This is most appropriate. We should all keep it and its implications before us constantly. We appreciate the efforts of this committee and we especially appreciate the opportunity to bring to your attention our concerns.

Thank you.

Report Of The Governor's Interagency Coordinating Committee On Long Term Care For Older Mississippians

Bill Allain, Governor
Beverly W. Hogan, Executive Director
Governor's Office of Federal-State Programs

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
JACKSON 39205

BILL ALLAIN
GOVERNOR

POST OFFICE BOX 139

January 30, 1987

Dear Elderly Advocates:

You have before you the products of the Elderly Long Term Care Coordinating Committee. The Committee, which I commissioned in September of 1985, was to undertake a study and examination of the long term care needs of Mississippi's elderly population, and report its findings and recommendations.

Some 12 various agencies were represented on the Committee which spent long hours in plenary and subcommittee sessions to meet the mandate it was given. I wish to personally thank our Council on Aging and each agency and representative for the time, interest, and expertise embodied in the report.

The content of the report and the recommendations proposed represent a critical and lofty challenge to all of us in meeting the long term care needs of our senior citizens. This will become an increasingly high priority in human services in the immediate years ahead.

I ask for your cooperation and effort to meet the purposes and goals in the report in the interest of our senior citizens.

You have the support of my office in these ongoing endeavors.

Respectfully,

Bill Allain

BILL ALLAIN
GOVERNOR

BA:rsh

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Introduction

In July 1985, Governor Allain called for the establishment of an interagency focus to deal with the development of a community based long term care network for aging services in Mississippi. To facilitate this mandate, the **Interagency Coordinating Committee on Long Term Care** was established.

In working to fulfill the direction of the charge it was given, the committee was to forward its policy recommendations to the Mississippi Council on Aging. The membership of the committee was appointed by the Governor, with Dr. David Brown, Director of the Mississippi Council on Aging, Governor's Office of Federal-State Programs, serving as Chair.

The Committee met monthly, sometimes weekly, from July 1985 through September 1986. Twelve distinct agencies, dealing with aspects of long term care, are represented on the committee, including members of the Statutory Council, the governing authority of the Council on Aging. Agencies represented include Public Welfare, Public Health, Mental Health, Medicaid Division, Veterans Affairs Board, Health Care Commission (now in the Department of Public Health), Independent Nursing Home Association, Mississippi Health Care Association, Mississippi Hospital Association, and the Departments of Job Development and Training, and Human Development, Governor's Office of Federal-State Programs.

To facilitate the work of the committee, four sub-committees were formed: Client Identity Pool, Service Systems/Technologies, Implementation Strategies, and Training — Staff Development. Recommendations contained in the report represent, in the main, those issues identified by the subcommittees.

The report represents a departure — a first step — in a broad outline of initiatives which are necessary, in the view of the committee, if long term care interagency networking is to become a reality in Mississippi. In the view of the committee, an appropriate and realistic response to the ever growing demand for long term care services among the state's elderly clients can only be met through a concerted, integrated and coordinated working relationship among the critical agencies represented on the committee.

The Mississippi Council on Aging extends its thanks and gratitude to the **Interagency Coordinating Committee on Long Term Care** for its time, labor, and commitment to serving the long term care needs of the state's older citizens. The work of the committee and the products of this report are a high testament to what can be achieved through interagency coordination and cooperation.

> ". . .Quality long term care to elderly Mississippians at the most appropriate level at the most affordable cost. . .

The Issue

Care of the elderly, particularly those most vulnerable and at risk is a complex and demanding issue of concern to all levels of government. Without a doubt, the challenge of addressing the long term care needs of a rapidly rising elderly population is the major national issue presently occupying the concern of policymakers, administrators and practitioners.

The focus on long term care in Mississippi derives from several realities including, the rapid growth of the 75+ population in the state, generally higher service and living costs, particularly in health care, the imperative of designing programs at appropriate levels of care with the maximum cost-benefit, the clear need to induce greater support systems for family and other caregivers, and the requisite for greater integration of effort among service agencies.

In its deliberations, the committee has propounded the following goals for Mississippi's long term care system:

1. To provide the most appropriate level of care to older persons in need of long term care services.
2. To enhance and sustain the role of family members and informal support systems in the care of frail elderly.
3. To improve and/or stablize physical functioning among frail elderly.
4. To improve and/or stablize psycho-social functioning among frail elderly.
5. To attempt to contain health care costs for a rapidly growing 70+ population.
6. To prevent the lack or duplication of service through community coordination and client monitoring.

Population Growth

Currently, 422,000 Mississippians, or two of every eleven people in the state, are 60 years of age or older. By the turn of the century, this older population will increase by 15 percent to 496,000. Nearly 150,000 people will be 75+ or 30 percent of the total elderly population. This latter group are those most likely to suffer from chronic conditions which inhibit activities of daily living and contribute to a loss of independence.

Social gerontologists note that, nationally, while some 33 million elderly currently report some limitation of activity due to chronic conditions, these numbers will soar to 43 million, an increase of 31 percent by the year 2000. Additionally, by the year 2000 the total number of physician visits will increase to 1.3 billion, a 20 percent increase from 1980. The largest increase will be among the group 75 years and over. Though these increases from Mississippi fall into the lower middle quartile when compared nationally, future projections indicate a 22 percent increase in activities limitation and an eleven percent increase in physician visits by the year 2000.[1] Clearly, it is this age group which will make major demands on Mississippi's long term care service systems and facilities. As the *Mississippi State Health Plan — 1986*[2] states:

> ". . .no matter what steps are taken to improve the plight of our State's elderly population eventually more money from governmental sources will be required to maintain programs. The alternative is to do nothing. . ."

Personal Preference

The Mississippi Council on Aging (MCOA) has recently completed a massive, statewide needs assessment which indicates the overwhelming majority of elderly persons wish to retain a sufficient level of independence and self care management so as to remain in their own homes, neighborhoods, and communities. As to preferred living arrangements, 79 percent of the respondents state the private family dwelling as the arrangement of choice. Of these, 62 percent have retired mortgages on their homes. Maintenance costs, however, is given as the primary reason for wishing to seek other living arrangements. One implication from these findings is that a significant number of elderly Mississippians live in fully amortized family homes for which maintenance costs and upkeep are a serious liability. The single family living arrangement may not be appropriate for current needs, particularly as ability to sustain traditional life styles declines with advancing years. Loss of independence is a universal fear. Therefore, in seeking the goal of the most appropriate level of care, client preference cannot be ignored.

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[1] Rice D., and Wick, A., "Impact of an Aging Population on Health Care Needs." Institute for Health and Aging, University of California, San Francisco, 1985. This study also projects a 37 percent increase in short-stay hospital days for elderly, and a 129 percent increase for those 85+. Nursing home care is projected to reach 2-3 million residents by the year 2000, a 64 percent increase since 1980. Nationally, demands for home health services are projected to increase 43 percent by the year 2000.

[2] *Mississippi State Health Plan — 1986*, Chapter X, "Long Term Care", pp. X-5.

Health Care Costs

The U.S. House of Representatives Select Committee on Aging has recently reported that per capita payments by elderly for health care will more than triple between 1977 and 1989, from $712 annually to an estimated $2409 annually. By 1989, according to the report, elderly will be paying 18.4 percent of their income for health care.

Table 1 depicts these comparative costs from 1977 to 1989, and the source of funds to cover these expenditures. The following charts (1-4), exhibit where out-of-pocket and Medicare-Medicaid dollars go in terms of elderly care.

Table 1

Personal Health Care Expenditures
For People Aged 65 And Older
In 1977, 1984 and 1989

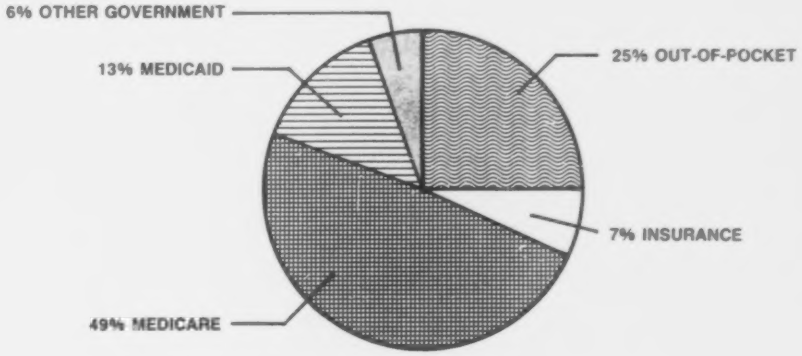
	Per Capita Health Expenditures		
Source of Funds	**1977**	**1984**	**1989**
Total	$ 1,785	$ 4,256	$ 6,637
Private	719	1,543	2,433
Consumer	712	1,526	2,409
Out-of-Pocket	522	1,072	1,705
Insurance	115	308	509
Medicare Premiums	75	146	195
Other Private	7	17	24
Government	1,066	2,679	4,204
Medicare	713	1,907	3,057
Medicaid	249	536	807
Other Government	104	236	340

SOURCES: House Select Committee on Aging, September 1984; Census Bureau, July 1984; Health Care Financing Administration, July 1984

Private sources such as employer-paid insurance are the major source of health care for persons under age 65. However, public funds are the major source for 65-plus persons.

Chart 1

Personal Health Care Expenditure For The Elderly By Source Of Payment: 1984



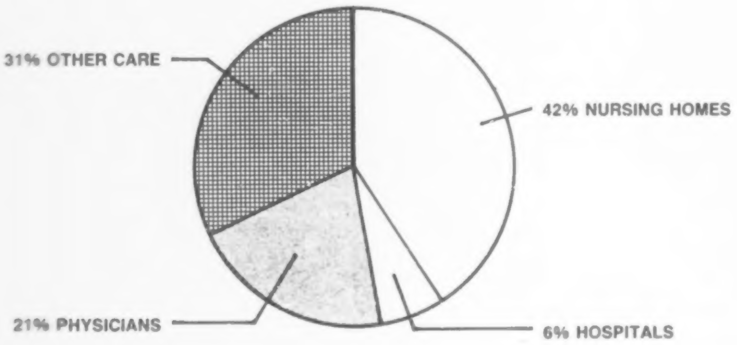
SOURCE: Health Care Financing Administration, Office of Financial and Acturial Analysis

Out-Of-Pocket Cost

Even with the substantial contribution of public funds, the elderly bear a considerable financial burden for health care out of their own pockets. Direct out-of-pocket health costs for the elderly averaged 15 percent of their income in 1984 — the same as before Medicare and Medicaid were enacted. Direct out-of-pocket health expenses for the elderly averaged $1,059 per person by 1984. The majority of these expenses are for nursing home care, physician visits and services, and health aids not covered by Medicare, Medicaid, or private insurance.

Chart 2

Where The Out-Of-Pocket Dollar For The Elderly Goes: 1984



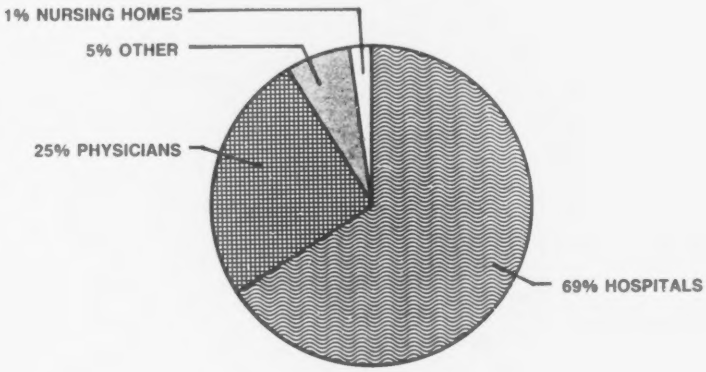
SOURCE: Health Care Financing Administration, Office of Financial and Acturial Analysis

Medicare

In 1984, Medicare was responsible for 49 percent of all personal health care expenditures. Costs for hospitals, which account for over 69 percent of all dollars Medicare spends for health care, are fueling Medicare's growth. The Congressional Budget Office has estimated that only 2 percent of the projected annual average 13.2 percent growth in hospital reimbursements from 1984 to 1985 will be due to the aging of the population.

Chart 3

Where The Medicare Dollar For The Elderly Goes: 1984



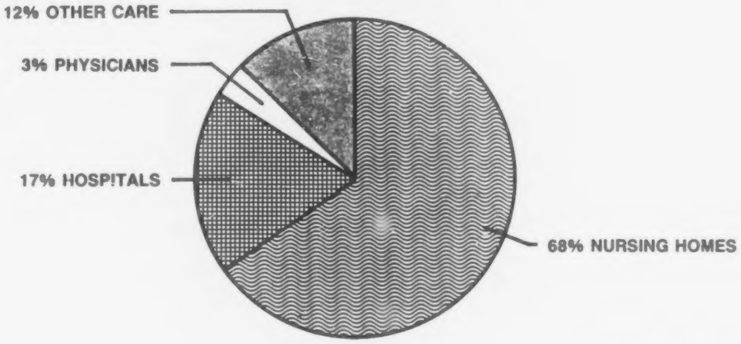
SOURCE: Health Care Financing Administration, Office of Financial and Acturial Analysis

Medicaid

Medicaid pays about 13 percent of personal health care expenditures for the elderly, the great majority of which is for that small portion of the population using long-term care. The gap between funding by Medicare, Medicaid, and out-of-pocket costs for health care for the elderly is covered by private insurance, foundations, and other Government sources such as the Veterans Administration, Department of Defense, Indian Health Service, States, and counties.

Chart 4

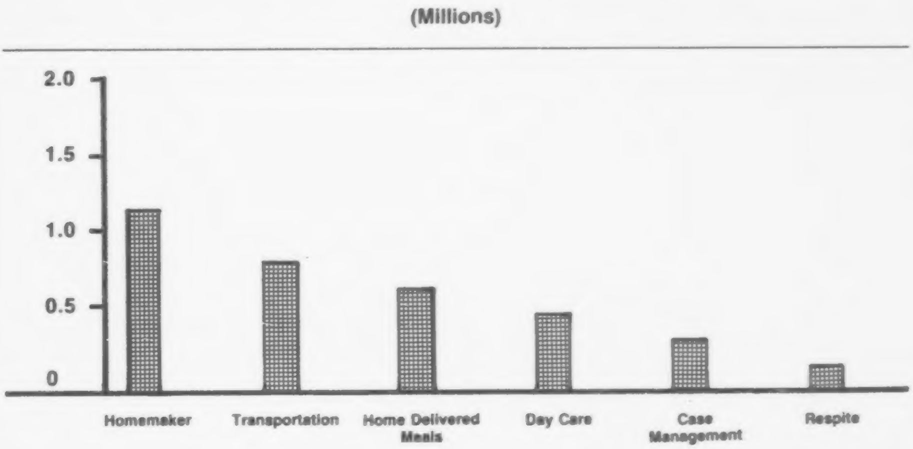
Where The Medicaid Dollar For The Elderly Goes: 1984



SOURCE: Health Care Financing Administration, Office of Financial and Acturial Analysis

In Mississippi, according to the Division of Medicaid report, July 1, 1984 - June 30, 1985, skilled/dual nursing homes rendered 1,678,342 days of care to 7189 Medicaid patients. The cost of this care was $54,589,709, or an average of $32.53 per day. By the same report, Intermediate Nursing Homes rendered 2.191,251 days of care to 8,592 Medicaid patients, at a cost of $58,307,676, an average of $26.61 per day.

In its community based long term care program, the Council on Aging utilizes Social Services Block Grant Funds (SSBG) to support the following array of services (FY 86):



Total: $4,907,680 (includes administration, state and local match and program income)

Under the Medicaid Home and Community Based Waiver Program, now a reality in Mississippi, approximately $478,000 is budgeted for a two county demonstration project in FY 87. Waivered services include case management, day care, homemakers, health aides, and respite care.* The intent of this program is two-fold: 1) to test cost effectiveness of community based services; and 2) to determine appropriate service level of community based programs for long term care clients.

> ". . .Older Mississippians are confronted with a myriad of problems, including a declining state economy, over which they have little control."

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* The Medicaid Waiver Program is administered by the Medicaid Division in agreement with the Council on Aging.

Elder Mississippians and Their Needs

The number of Mississippians 60+ will grow by 15 percent by the end of the century and reach almost one half million. This is a 140 percent increase since 1950. The "graying" of Mississippi will continue to reflect national trends with a population increase of 183 percent in the 75+ population from 1950 - 2000. This latter group, as has been pointed out, comprise the most frail, at risk group to whom long term care services are targeted.

Poverty Among the Elderly

Approximately 32 percent of all Mississippians 60+ live below sanctioned national poverty guidelines. This represents a population of approximately 140,000 older adults. The incidence of poverty increases with age among all elderly and at an even higher rate among minority elderly. Minority females and individuals living alone constitute the poorest segment of the older population. Priorities among this poverty group are medical bills, food stamps, purchase discounts, repair services, utility bills and transportation.

Life Satisfaction

Among the major findings in the MCOA Needs Assessment* is a critically strong relationship between socio-economic status (SES) and life satisfaction. Those reporting inadequate incomes, serious health problems, lower education levels and social isolation, report significant levels of life dissatisfaction. These elderly report significant disabilities in social relationships, lack of awareness of services and entitlements, more serious emotional problems, high stress and high levels of loneliness and boredom. This latter correlate is of particular significance in levels of life dissatisfaction, thereby indicating that community programming which stresses social interaction and collegial activities of a group or communal nature may significantly enhance levels of life satisfaction. Such programs are likely to be less costly and, therefore, more available than services focused more narrowly on health or physical needs. The point to be made, is that programs which ensure ongoing social relationships rapidly need to be enhanced in support of needed health care modalities.

However, for the group depicted above, disabilities are multiplied at an exponential rate, i.e., a disability in one area, isolation for example, leads to other disabilities. A profile of high life dissatisfaction elderly is: female, minority, lives alone, has unattended medical problems, and inadequate nutrition. This is, additionally, a population which is highly socially isolated, has few or no social contacts, and engages in little or no volunteer activities.

Highly Demanded Services

MCOA's needs assessment has documented the following as highest priority programs as reported by elderly along with a number of professionals such as agency directors, and human and health services executives.

High priority services are those dealing with public education regarding consumer protection against various frauds and/or "con" games which prey particularly upon the elderly, coupled with enforceable legislation to protect older adults from financial exploitation, abuse, and/or neglect. Energy assistance, emergency life line and telecommunication programs, expanded social opportunities such as tours and social events, senior discount programs, transportation and employment opportunities are also deemed of highest priority.

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*The sampling ratio of the needs assessment is 1:242 people 60+

Access to assistance programs, community based services, rural outreach and expanding medical benefits were programs additionally receiving priority mention.

It is noteworthy that most, if not all, of the service priorities mentioned in the assessment speak to maintaining financial, economic and physical independence and sustaining the individual in the most preferred environment — the home and community. Like the rest of us, elderly people prioritize economic well-being in their scale of social and personal values.

> ". . .The real issue in aging services in Mississippi is to document true need at an appropriate care level at reasonable cost. . ."

Aging Services in Mississippi

It is axiomatic that fiscal and human resources correlate directly with levels of service. Throughout the history of the aging network in Mississippi, the fiscal resource base has been generated overwhelmingly on the federal level. The one exception is the "critical mass" of local matching funds which is the livelihood of the aging funding system. An additional and likewise critical funding source springs from voluntary program contributions which elderly make for services they receive. In FY 85, this local self-help investment reached $425,000 in the Title III programs, and $107,000+ in the SSBG program. Increased emphasis is nationally being placed on cost sharing services among those elderly with the means.

Community Based Care

The Mississippi Council on Aging has recognized that in order to provide the most appropriate care for its elderly citizens, a wide range of services must be available in both the public and private sector, and on the institutional and community level. These latter services are targeted to that population in need of assistance, but not requiring nursing home care. In other words, all needed services have a place in the continuum of care and that continuum reaches across the public and private sector and spans both the community and long term care institutions. (See *Continuum of Care Profile*, page 12.)

The spectrum of services provided to long term care clients by MCOA includes, 1) in-home services such as home delivered meals, homemaker, health aides, respite, life line, case management and critical care nursing, 2) community based services such as legal assistance, transportation, senior center and day care services, and congregate meals; and 3) institutional-based services such as friendly visitation and ombudsman programs. These services are focused on individuals with documented levels of prescreened need and eligibility and are drawn from the core package of long term care services currently available. (See Appendix I.)

Additionally, the Council on Aging has recently developed a management information system (MIS) which is computer based, and network wide. Vital service profiles, client logs, and client tracking displays from the core of the MIS. Unit cost data is currently being established which will provide critical base line data on unit of services and costs for long term aging care.

Continuum of Care Profile

Community Care	Institutional Care
Program Objectives	
Community-based long-term care assists at-risk, vulnerable adults to remain independent and self-sufficient as long as possible by providing homemaker, meals, case management and other services.	Institutional care is appropriate for needy aged who have health problems requiring medical and custodial care in a long-term health facility.
Services	
Homemaker, health aides Home delivered meals Nursing care Case Management Day Care Legal Assistance Protective Services	ICF — intermediate care for persons who need help in daily living and who have medical needs requiring episodic nursing care SNF — skilled care for those with comprehensive health problems requiring nursing care on a 24-hour basis
Eligible Population	
There are approximately 138,000 Mississippians 75 or older.	There are approximately 7,000 elderly in skilled care facilities and 8,500 in intermediate facilities.
Eligibility for services is based on prescreened need.	98,000 elderly are SSI recipients automatically eligible for medical assistance.
98,000 are SSI recipients earning less than $180.00 monthly. An additional 40,000 are blind and otherwise handicapped.	Nursing home bed need for 1990 is projected at 17,377 and for 2000 at 18,661.*
It is anticipated that in FY 87, 20% or approximately 14,000 elderly will be reached by one or more long term services.	Approximately 4.8% of the population 60+ are in nursing homes.

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* Bed need calculated @ 49.37/1000 — Health Care Commission State Plan, 1984-86

Populations at Risk

MCOA needs assessment data* reveal that 13.4 percent of elderly report their health status as poor, meaning health status prohibits them from performing necessary activities of daily living. Additionally, 43.6 percent report fair health status, meaning they perceive steady though incremental decline in health status. Seven percent report excellent health status. The great majority, 42 percent, see a doctor only several times a year, and 57 percent see a dentist or eye doctor once a year or less. Costs and lack of transportation are reasons given for not seeking needed care more often by 58 percent of respondents. Almost 30 percent report that they usually treat themselves. Arthritis, high blood pressure and heart problems are the most frequently reported disabilities.

Interestingly, 91 percent report eligibility for Medicaid, while only 37 percent have established Medicare eligibility. While 56 percent report having private health insurance, 82 percent have burial policies. Those who perceive inadequacies in the Medicaid program do not feel the program, as currently mandated, is generous enough.

Elderly in the state report an average of five days hospitalization over the last two years, and claim they receive major assistance upon discharge from family members and home health, homemakers services.

Five percent report inadequate nutrition intake and state lack of money and/or food stamps as the major barrier to adequate nutrition. Eighty-eight percent report the recent loss (last two years) of a relative or spouse, and 8 percent have been victimized and/or exploited/abused over the same two year time frame. Seventy-six percent report a theft or break-in, and 10 percent report verbal abuse and confinement as major aspects of abuse directed toward them.

From this data, however, the strongest **relationship among all factors determining levels of life dissatisfaction, is education level. Those elderly with less than a high school educational background report across-the-board disabilities to a greater extent than when measured against other variables such as age, income, sex, race and living arrangement.** Sex and race are the next highest correlates to levels of life dissatisfaction especially among black females who live alone. Income ranks with age, particularly among the 75+ population, as the next highest correlate. Urbanism, rurality, and living arrangements, though significant, show weaker relationships to life dissatisfaction than the above factors.

The greatest factors detracting from general life satisfaction in the older years are isolation, loneliness and boredom. For the policymaker, this finding has clear implications for programs which place a premium upon socialization, group interaction, and meaningfully planned activities which enhance opportunities of social exchange and interaction.

> "...The vast majority of Older Mississippians wish to remain independent as long as possible and seek those programs which enhance economic well-being. Physical and social needs, particularly the need to be a valued member of a social group, rank with preferences dealing with economic well being."

Recommendations

I. Preadmission Assessment

Issue

In FY 85, MCOA introduced prescreening and client assessment instruments which measure functional capacity to carry on activities of daily living among elderly clients. These instruments

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* Sample ratio = 1879 interviews @ 1:240 60+ population.

(See Appendix I), also measure socio-economic status and family and other support resources clients hold. Eligibility for long term care services are based upon scored assessments derived from the instruments, which form the basis of the Mississippi Council on Aging's management targeting system.

Recommendation:

That prescreening for admission to nursing homes or other long term care institutions continue to be carried on by the Medicaid Office. Consideration be given to the feasibility of contracting the screening function to a capable agency which would maximize the use of nursing, social work, and medical staff in such determinations. It is further recommended that consideration be given to the utilization of a case management team approach to preadmission screening to those clients establishing Medicaid eligibility for long term institutional care. Elderly clients with established eligibility who cannot secure institutional placement, can be considered for referral to MCOA's long term care program and/or the Medicaid Waiver Program.

Rationale

- Development and use of a continuum of appropriate care depends on accurate assessment of clients and an integrated system of appropriate referral.
- Utilization of functional criteria for appropriate placement will insure clients receive the level of care which most nearly meets their need, be it community based or institutional.
- Integrated prescreening procedures are widely used in many other states, many of whom have vested such procedures in legislation.
- Data on the number of nursing home applicants needs to be derived from the Medicaid office along with conversion data on clients who move from private to public support. Preadmission assessment can be funded through Medicaid 2176 waivers, or Title XX.

Such a recommendation was also supported by the Report of the Advisory Committee to the Special Study Committee on Indigent Care. The report calls for the establishment of such procedures in FY 87. (See Report, December 1985, p. 15)

II. Personal Care

Issue

Many elderly Mississippians require assistance with activities of daily living to remain independent. Funding for community based supportive care, particularly under the expansion of the Medicaid Waiver Program, is a critical and mandatory priority.

Recommendation:

That the Mississippi Legislature establish a select committee on long term care and study appropriate funding alternatives for community based services. The Interagency Coordinating Committee membership, to include legislative representation, should be expanded to accomplish this purpose.

Rationale

- Community based and institutional services work best hand-in-hand, on a partnership basis, to accomplish the desired goal of appropriate levels of care.
- Community based care is a nationally emerging program receiving increased attention from Congress and among state legislators. Evidence mounts that such care is cost effective among carefully screened clients establishing clear need.
- The Interagency Coordinating Committee and Indigent Care Advisory Committee both endorse this concept. Currently, Mississippi does not have mandated community based system in place. It is a fundamental goal of the Interagency Committee to work toward this end.

Opposition

The legislature already has adequate committee mechanisms in place for the consideration of long term care issues.

III. Home Health Care

Issue

The scope and range of Medicaid home health services is inadequate to meet the goal of establishing an appropriate level of care continuum. Services only include those federally mandated with limited visitation.

Recommendation:

That the Medicaid Waiver Program be legislatively mandated as a statewide option with appropriate funding, realisticaly to expand the program.

Rationale

- Home health services can be constituted as a viable integrative array of services within MCOA's community based services, thus coupling social support with health oriented services.
- Personal care/nursing services need more closely to be integrated with the array of home service offerings, as an integrated aspect of the case management team approach to home and community service.
- The 2176 Waiver Program could well be utilized, along with the SSBG Negotiated Investment Strategy program, to effect sound interagency effort in bringing together social and health services on a community and home basis.

IV. Alternative Living Arrangements

Issue

Congregate housing and shared living arrangements can provide suitable and semi-independent life styles for many elderly clients. These programs provide a residential environment including meals, housekeeping, health services and transportation. MCOA has funded a shared living model project in the Tupelo area with a significant modicum of success. Retirment communities are slowly being introduced in Mississippi, largely by private developers, as yet another alternative which offers a broad range of services such as private residence, day care, and institutional care within the same locale.

Recommendations:

That the State of Mississippi prioritize the development of congregate and shared living arrangements through the coordination of appropriate funding sources.

Rationale

- Congregate living can be provided in a variety of settings including apartments, personal care homes, and private dwellings. Such arrangements offer relief to critically high rates of nursing home occupancy, particularly given the current moratorium on bed expansion and the length of placement waiting lists.
- The MCOA needs assessment clearly indicates the larger majority of elderly prefer independent or semi-independent living arrangements. Such arrangements may well serve as a viable transition between institutional care and independent living.
- As the recent MCOA study shows, 40 percent of homes owned by the elderly were built before 1939. Maintenance, repair and upkeep are prohibitive cost items. Some 15,314 homes occupied by elderly are deemed inadequate and in immediate need of weatherization and other repairs. (U.S. Department of Housing and Urban Development. "Mississippi elderly Housing Stock Survey", 1984.)

V. Respite Service

Issue

In Mississippi, some 75-80 percent of all care given to elderly is provided in the home by family members. However, as disability becomes more severe the family's ability to provide care is greatly strained.

Recommendation:

Alternative settings should be considered as a service base for respite care. Along with in-home relief, hospitals and nursing homes need to be critically prioritized as most appropriate settings for respite care delivery. Expanding the capability of senior centers, community facilities, and day care facilities to provide respite care needs likewise to be programmatically developed.

Rationale

- The need for respite care in alternate settings is among the most highly suggested recommendation by the Committee.
- State and national data clearly demonstrate the accumulation of daily stress placed on family care givers.
- Respite is a proven cost-effective way to reduce care giver stress, enhance the informal care system, and sustain clients in a most preferred environment.

VI. Nursing Home Outreach

Issue

Nursing homes need to be encouraged to offer a greater array of community based services. Facilities such as VFW posts can well serve in a community outreach program. Special attention needs to be given to the swelling aged veteran population.

Recommendation:

That diversified outreach programs from long term care facilities be developed to serve at risk elderly in Mississippi and that increased flexibility in funding, such as the waiver program be considered in terms of fully utilizing nursing homes in community based services.

Rationale

- The nursing home is a viable community based service provider with proven capacity such as meals preparation, medical counseling, drug control, respite and the like.
- Staff members in these facilities have invaluable training in dealing with elderly clients.
- The nursing home and its staff are mandatory participants in a well convened program of community care.

VII. Service Integration

Issue

Several agencies currently serve the long term care needs of elderly clients in Mississippi. To better leverage funding and to effect the highest level of service coordination, the Governor instituted the Interagency Coordinating Committee on Long Term Care. Throughout its short life, the committee has sought effective and efficient ways to address the myriad of issues involved in the implementation of long term care systems. Various legislative initiatives have also been submitted seeking profoundly to reorganize health care administration in the state. The Indigent Care Study Group has recommended such a general approach.

Recommendation:

That the Interagency Coordinating Committee continue its work to meet the goal of interagency cooperation, program integration, and pooling of resources to establish a state-level system of long term care service delivery.

Rationale

- The concept of integrated service delivery in long term care was adopted by the Indigent Care Committee on which many members of the Coordinating Committee sat.
- Effective use of Medicaid and SSBG funds in a "mixed model" approach will require common goal sharing among agencies and greater coordination between health and social service delivery.

- A realistic continuum of care ranging from social to health services can be developed by using standardized eligibility and assessment measures to ensure the clients receive the most appropriate care most of the time.

- Application, intake and referral procedures need to be centralized and less duplicative for clients.

VIII. Protection of Rights

Issue

The current Vulnerable Adults Act is an excellent example of interagency cooperation utilizing SSBG formats and funding. The legislation sunsets September 30, 1987. Cases have been documented in every county of the state showing incidents of exploitation, neglect, and/or abuse of the elderly. Loss or denial of entitlements, and financial exploitation are likewise documented. Mississippi needs to extend to older adults protection legislation, which given the above realities, is a priority need.

Recommendation:

That legislation be extended to assure the rights of elderly and disabled Mississippians are protected in such areas as abuse, competency hearings, powers of attorney, protection of entitlements and guardianship.

Rationale

- Not uncommonly, the elderly are institutionalized without prior consultation and consent nor are they fully advised of their rights as patients.

- Due to vague statutory protection, power of attorney is easily transferred from the elderly. As a result, property and possessions often pass into the hands of others thus making these victims publicly dependent.

- The MCOA needs assessment shows that in the last two-year period, 306 of 1879 reporting elderly state at least one incident of abuse, and in the same time period, 381 report more than one incident. The vast majority of these report insults, threats, and denial of care.

- Elderly abuse prevention is currently a major national priority with the Administration on Aging and the National Association of State Units on Aging and Area Agencies.

IX. Volunteers

Issue

Volunteers provided approximately 14,000 hours of service in FY 85 to the aging network. These activities ranged from assistance in nutrition sites, ombudsman programs, senior centers, and service on various boards and councils. During this period of fiscal cutback, it is urgent that volunteer assistance be aroused to the maximum.

Recommendation:

That the Mississippi Legislature and Statutory Council encourage all facets of the aging network to expand existing volunteer programs and initiate new programs for recruiting, training, and placing volunteers to work with the elderly.

Rationale

- Elderly are particularly effective volunteers with their own cohorts.
- Volunteer programs generate citizen and community involvement which is the life blood of the aging network.
- Volunteers are a clear cost-effective alternative to dependence upon shrinking state and federal dollars.

X. Insurance

Issue

Elderly and disabled Mississippians have great difficulty obtaining adequate and appropriate insurance coverage, particularly in the long term care area. Inappropriate policies are a major source of financial exploitation among the elderly.

Recommendation:

That appropriate legislative committees with the cooperation of the State Board of Insurance closely examine the adequacy and provision of insurance to the elderly which most closely meets their needs.

Rationale

- Comments by the Insurance Commissioner to the MCOA Statutory Council clearly document the needs for massive educational efforts to inform elderly Mississippians about the availability and adequacy of policies they purchase.
- Long term care insurance is an emerging national priority within the aging network as a possible means of funding the protracted health care needs of elderly persons.
- As noted previously, MCOA's needs assessment shows that 89 percent of elderly have no current insurance through an employer, 44 percent have no private insurance and 65 percent have no life insurance.

XI. Staff Training and Development

Issue

Throughout its deliberations, the committee has reiterated the need for joint training among and between agencies in order to facilitate a clearer understanding of the roles, functions, and services each delivers. Joint advocacy, sharing of educational materials, and joint legislative activity in behalf of long term care programming are among the strategies suggested in behalf of this recommendation.

Recommendation:

That the Interagency Coordinating Committee move to adopt a training curriculum in long term care for appropriate agency staff.

Rationale

- A common training initiative will best familiarize staff with the programs and services offered among agencies in state with long term care concerns.
- Mutual sharing of staff skills and program technologies will enhance the enrichment and capacity of program delivery and lead to sound integration of effort.
- Common advocacy and legislative initiatives are most likely to emerge from a well founded training and staff development initiative.

Other entities within the aging network such as the Long Range Planning Committee and the Interagency Coordinating Committee are currently studying ways in which the issues raised herein can be comprehensively confronted and addressed. Mississippi sorely needs such a long range vision to meet the great challenges ahead of meeting the needs of its fastest growing population — elderly citizens.

Bibliography

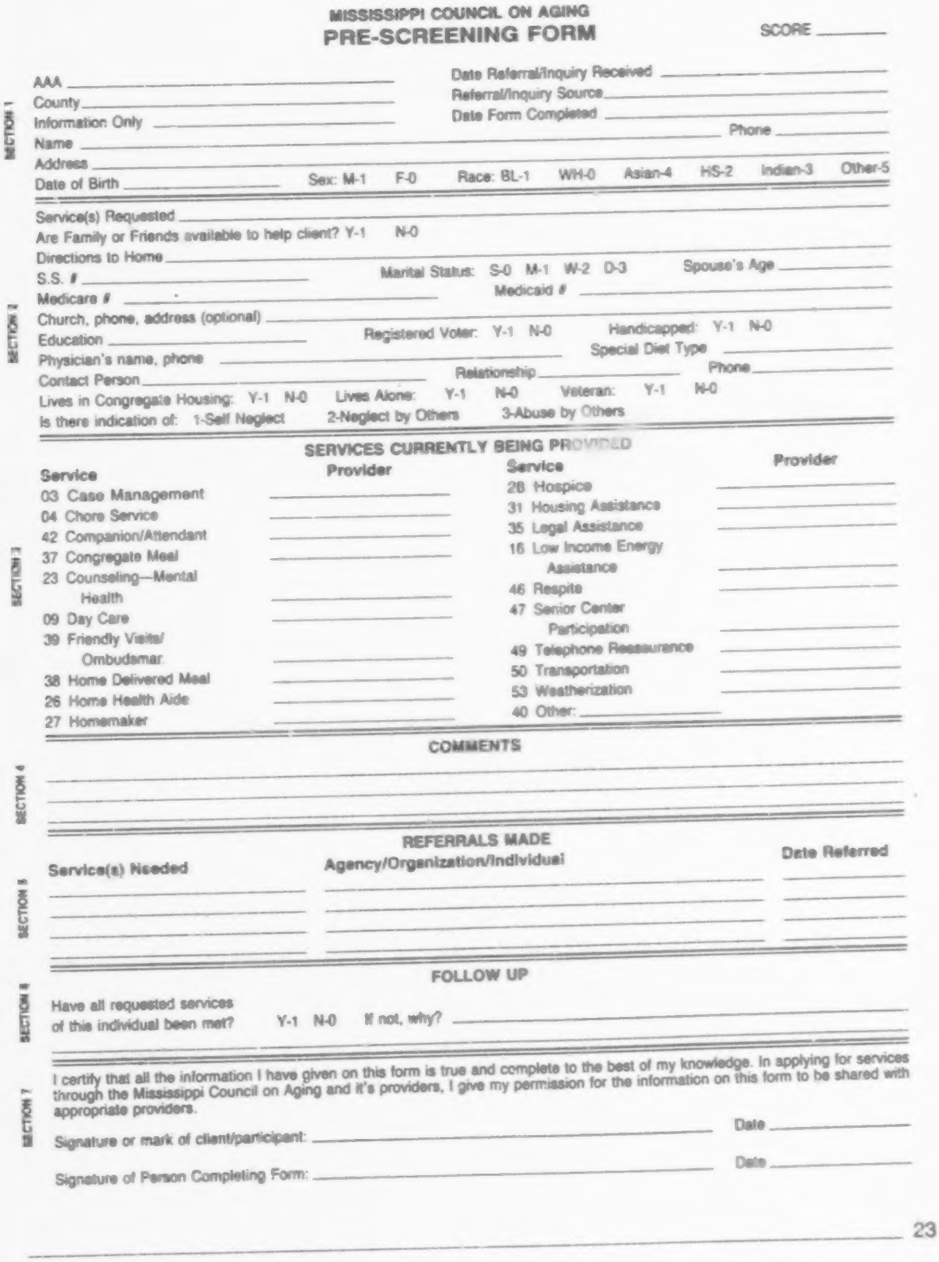
Rice D., and Wick, A., "Impact of an Aging Population on Health Care Needs." Institute for Health and Aging, University of California, San Francisco, 1985. This study also projects a 37 percent increase in short-stay hospital days for elderly, and a 129 percent increase for those 85+. Nursing home care is projected to reach 2-3 million residents by the year 2000, a 64 percent increase since 1980. Nationally, demands for home health services are projected to increase 43 percent by the year 2000.

Mississippi State Health Plan—1986, Chapter X, "Long Term Care", pp. X-5.

Appendices

I. Pre-Screening Form

II. Summary of Findings — Recommendations, Mississippi Council on Aging Needs Assessment



MISSISSIPPI COUNCIL ON AGING

PRE-SCREENING FORM

SCORE ______

SECTION 1

AAA ______ Date Referral/Inquiry Received ______
County ______ Referral/Inquiry Source ______
Information Only ______ Date Form Completed ______
Name ______ Phone ______
Address ______
Date of Birth ______ Sex: M-1 F-0 Race: BL-1 WH-0 Asian-4 HS-2 Indian-3 Other-5

SECTION 2

Service(s) Requested ______
Are Family or Friends available to help client? Y-1 N-0
Directions to Home ______
S.S. # ______ Marital Status: S-0 M-1 W-2 D-3 Spouse's Age ______
Medicare # ______ Medicaid # ______
Church, phone, address (optional) ______
Education ______ Registered Voter: Y-1 N-0 Handicapped: Y-1 N-0
Physician's name, phone ______ Special Diet Type ______
Contact Person ______ Relationship ______ Phone ______
Lives in Congregate Housing: Y-1 N-0 Lives Alone: Y-1 N-0 Veteran: Y-1 N-0
Is there indication of: 1-Self Neglect 2-Neglect by Others 3-Abuse by Others

SECTION 3

SERVICES CURRENTLY BEING PROVIDED

Service	Provider	Service	Provider
03 Case Management	______	28 Hospice	______
04 Chore Service	______	31 Housing Assistance	______
42 Companion/Attendant	______	35 Legal Assistance	______
37 Congregate Meal	______	16 Low Income Energy Assistance	______
23 Counseling—Mental Health	______	46 Respite	______
09 Day Care	______	47 Senior Center Participation	______
39 Friendly Visits/ Ombudsman	______	49 Telephone Reassurance	______
38 Home Delivered Meal	______	50 Transportation	______
26 Home Health Aide	______	53 Weatherization	______
27 Homemaker	______	40 Other: ______	

SECTION 4

COMMENTS

______

SECTION 5

REFERRALS MADE

Service(s) Needed	Agency/Organization/Individual	Date Referred
______	______	______
______	______	______
______	______	______
______	______	______

SECTION 6

FOLLOW UP

Have all requested services of this individual been met? Y-1 N-0 If not, why? ______

SECTION 7

I certify that all the information I have given on this form is true and complete to the best of my knowledge. In applying for services through the Mississippi Council on Aging and it's providers, I give my permission for the information on this form to be shared with appropriate providers.

Signature or mark of client/participant: ______ Date ______

Signature of Person Completing Form: ______ Date ______

SCREENING CRITERIA

Score each of the areas below based upon interviewing the person or, if the client/participant is unable to respond, on observation and/or information from caregivers, family, etc.

SECTION II

Age
0 Under age 60
1 Age 60 - 69
2 Age 70 - 74
3 Age 75 - 84
4 Age 85 & Over

Race
0 Non-minority
2 Minority

Transportation
0 Not needed
5 Needed

Living Environment
0 Satisfactory
3 Unsatisfactory

Speech
0 Normal
3 Speech impaired
5 Mute (unable to speak)

Hearing
0 Normal
3 Hearing impaired
5 Deaf (unable to hear)

Emotional Status
0 Normal
3 Feels depressed, apathetic or lonely

Feeding
0 Independent
3 Cannot cook
5 Cannot feed self

_____ Sub-total, this column

Family Income (Client & Spouse)
0 Refused
5 Under $200/mo.
4 $200 - $399/mo.
3 $400 - $699/mo.
2 $700 - $999/mo.
1 Over $1000/mo.

Ambulatory Status
0 Independent
3 Walks with assistance
3 Wheelchair-bound
4 Needs help from bed to chair
5 Bed-bound

Vision
0 Normal
3 Impaired
5 Blind

Mental Status
0 Appears alert
5 Appears confused

Dressing
0 Independent
4 Needs help with dressing
5 Cannot dress self

Bathing
0 Independent
3 Needs help with bathing
4 Needs help with bed bath
5 Requires complete bed bath

Elimination
0 Independent
4 Needs help to bathroom
5 Incontinent

_____ Sub-total, this column

SCREENING SCORE: _____

Add scores from above columns and transfer to the "SCORE" line on the front.

SECTION III

DENIAL/TERMINATION OF SERVICE

Denial-1 Termination-0 Date ______________ Signature ______________________
Reason ____
____
____
Hearing Requested: Y-1 N-0

Summary of Recommendations of MCOA Needs Assessment

The following recommendations are suggested by the interview and sampling data:

1. The general need for improved transportation was mentioned more often than any other area of concern. Buses and vans do not always stop at places that are convenient for many older adults. Others would like to have transportation available in the evenings and on weekends.

2. The greatest single concern expressed by many seniors was inadequate financial means. The ramifications from this are obvious. More specifically, not having enough funds to pay medical bills is a frequent concern.

3. Many people needed help with housework, repairs, yardwork, etc. Some respondents were willing to pay someone to come in to assist them. Others could not afford this assistance.

4. Many expressed need to be with others. Social fellowship was important. Places to congregate and participate in planned activities such as crafts, gardening club, exercise program, classes of various kinds; and outings such as fishing, hunting trips, visits to places of interest, were suggested as means of extending social relationships.

5. Particularly, medical bills were a large concern. Inadequate coverage under Medicare or Medicaid is critical. Many felt these programs should pay more of the costs. Some have trouble paying before reimbursements are received. Many cannot afford needed glasses, dentures, hearing aids, etc. Most have trouble understanding the eligibility rulings and feel they should be eligible because they need services and cannot afford them.

6. Many expressed the need for someone to visit them on a regular basis because of loneliness and to check on their needs. An "adopt a grandparent" program was suggested.

7. Much concern was expressed about the high cost of utilities. Heating bills in the winter were mentioned most; people in rural areas had a particular concern in this area.

Suggestions With Minimal Expenditures:

1. Strongest support was shown for programs that would educate older consumers regarding fraud and embezzlement. Pressure to purchase unneeded burial insurance and health insurance policies which are not adequate and appropriate is a clear exploitative issue.

2. Provide eligible older adults home energy assistance funds at the time they must pay their bills rather than weeks later. (It might be possible, in some instances, for an agency to work out arrangements whereby utility companies would bill older adults receiving Home Energy Assistance a month later than normal.)

3. Effective communication networks are one means by which loneliness and boredom can be reduced. There already exists, for example, telephone reassurance programs in some AAA's. This program should be expanded to all AAA's. Senior volunteers can assist in programs such as telephone reassurance with minimal expense to agencies.

4. Combat the loneliness/boredom many seniors feel with social events, tours, hobby groups, contests, pet ownership and sports events. Churches, social and civic groups, and corporations need to be encouraged to sponsor such events.

5. Hire more older adults who can use their talents and understanding to help senior citizens.

6. Provide special **recognition** to older adults who volunteer their services to help other seniors.

Suggestions With Moderate Expenditures

1. Increase use of services by local organizations to assist older adults (churches, libraries, schools, etc.).

2. Find ways to greatly simplify the forms and processes through which older adults apply for assistance.

3. Find ways to distribute food stamps and food surplus without the elderly waiting in long lines or traveling great distances.

4. Empower one agency in each locale to coordinate interagency planning to minimize duplication of services.

5. Use available transportation better by charging according to ability to pay and by scheduling services when/where needed.

6. Develop a standing committee within the State Legislature to overview laws and policies to assist older adults.

Suggestions With Higher Expenditures:

1. Enact enforceable legislation to protect older adults from abuse and exploitation of property and finances.

2. Alert lawmen, postal employees, and others in regular contact with the elderly to check on their well-being.

3. Encourage seniors who need and can pay for home delivered meals to make a contribution toward the meal costs.

4. **Enact long-term care legislation affecting seniors.**

5. Review older adult insurance laws and provisions to ensure competitive pricing and clearly stated benefits.

6. Allow family members to take tax credits when they are primary providers of care for the elderly.

These and the many other suggestions from the second survey should also be given careful consideration. It is important to recall that these latter suggestions originated from professionals who have had much experience in working with older adults.

The Mississippi Council on Aging is impressed particularly with findings suggesting strong correlations between perceptions of life satisfaction and socio-economic status (SES) factors. These correlations are rather direct. High SES equates high life satisfactions. The converse is strongly correlated. From these major findings, the following trends are suggested:

1. SES factors such as age, education level, sex, race, and income are major variables impacting on life chances and opportunity. Younger populations need to become clearly aware of the necessity to plan for aging and positively manipulate private resources as fully as possible to avoid late dependency.

2. Safety net programs need to be enhanced which address clear need among low SES elderly. This is a population with little opportunity to manipulate life conditions.

3. Massive public education regarding the nuances of aging is mandatory for the entire sector of the state's population. Aging in Mississippi is truly a high item on the social programming agenda of the state. There are many implications springing from this issue. This report has attempted to reflect some of them.

Senator **Matsunaga**. Thank you, Ms. Mapp.

We would be happy to hear from you, Mr. Carroll.

Mr. **Carroll**. Thank you, Mr. Chairman.

My name is Bill Carroll. I live in a small town in northeast Mississippi called Tupelo. I am here today in a dual capacity, as a professional in the field of long-term care services to the elderly and as a family care giver of a victim of Alzheimer's disease.

Professionally, for 22 years I have been the Executive Director of United Methodist Senior Services of Mississippi, Inc., a nonprofit organization which provides a multitude of services to older persons without regard to their race, their religious affiliation, or their economic circumstances.

We have been fortunate enough to be involved in the provision of services under the Older Americans Act continually since 1969. We have had the opportunity to see this program grow through the years and we have had the opportunity to participate in its continuing maturity.

Let me assure you that it is an extremely valuable resource in our area. But I am also here today as a representative of a family in which Alzheimer's disease has had a devastating effect. My brother, Jack, a productive citizen for more than fifty years and a successful insurance agent, was diagnosed as apparently having Alzheimer's more than five years ago.

Although he continued to work at his job, he was less and less productive and finally had to give it up. For over two years, Jack was cared for at home. For three years now, he has been a patient in a skilled nursing facility. While Jack was at home, his wife Sara served as the primary care giver. Other family members and friends gave limited assistance. Sara had been an outstanding elementary schoolteacher for many years but was forced to take early retirement in order to care for Jack. This curtailed their income significantly.

Soon they had to dismiss the part-time help which they had employed. They were not eligible for services at that point under the Older Americans Act. This loss, plus the physical and emotional drain on the primary care giver was devastating.

The day came when Sara had to make institutional arrangements. The number of nursing beds available to Alzheimer's patients in our area is extremely limited. In the days when I worked on the specific development of services to Alzheimer's patients and their families, I never realized how important it would become for my own family. The cost, both fiscally and emotionally, is very high, but with the assistance of several family members and friends, the bills are being paid and Sara is struggling to get back.

From my dual perspective, let me make some observations and a few recommendations. The rest will be a part of the record. I hope that the Committee members and the Committee staff will take into account both the years of professional experience and the personal pain which my statement represents.

Number one, the needs of the elderly can best be defined by the elderly themselves. There are too many so-called "experts" (maybe like me) who are drawing conclusions and making plans for older people without adequate input from elders themselves.

Two, the local resources which may be utilized in addressing the needs of the elderly are far greater than government sometimes seems to recognize, and sometimes the people at the local level seem to recognize as well. These local resources need to be cultivated and encouraged on every hand.

Three, access to the service delivery system is often cumbersome and terribly impersonal. Administrative procedures and paperwork often discourage participation in needed services by the elderly and their families.

Four, services to the rural elderly are difficult and they are expensive. Mississippi is both rural and poor. Programs which have been designed primarily to meet the needs of the urban elderly are often very difficult to adapt to our situation.

Five, access to the service delivery system should not be denied to older persons solely because of their financial resources, either because of a lack of them or the greatness of them. Need is not always defined in financial terms. Senator, I could preach on that, as a Methodist clergyman, if you would let me. Sometimes this need is seen in the lack of services available to address a particular situation, but oftentimes it is seen in the lack of access to existing services. For example, the present very low income targeting requirements imposed by the Department of Housing and Urban Development in its regulations are keeping some truly needy persons from a safe and secure living environment solely because of their income.

Six, the programs funded under the Older Americans Act have become a real stimulus to local and regional organizations in planning and developing complementary services. This has been especially true when training programs were aimed at a more general audience, rather than just at professionals in the aging field.

Seven, the lack of flexibility in the use of funds has often caused locally identified needs to have a lower priority in program development and implementation.

From this perspective, I would like to submit the following recommendations, and I will only mention one or two of those:

The Older Americans Act should mandate significant input at every level by older persons in the program planning and evaluation. For instance, the Federal Council on Aging should have a majority of its membership drawn from older persons.

Number two, I recommend reauthorization of the Older Americans Act for at least a three-year period, without making changes. The act should provide sufficient funding for Older Americans Act programs, particularly Title III community service programs such as congregate and home-delivered meals, homemaker services and the like.

Support the development of innovative local approaches for meeting the needs of the communities' elderly, particularly in the development of local, community based long-term care systems.

Build safeguards into the case management system which will provide freedom of choice to the beneficiary and the provider, while ensuring the provision of quality services and efficient utilization of community resources.

Continue the efforts to develop some special approaches through training and demonstration grants to the unique cultural needs of ethnic and racial minority elderly.

Finally, encourage through supporting pilot programs the development of models which may be used to more effectively assist care givers of persons suffering from Alzheimer's and related disorders.

Thank you for giving me this opportunity to give you a piece of my mind and a little bit of my heart at this hearing.

[The prepared statement of Mr. Carroll follows:]

TESTIMONY OF J. W. CARROLL
MARCH 31, 1987

My name is Joseph William Carroll. I am a resident of Tupelo, Mississippi. I am here today in a dual capacity: as a professional in the field of long-term care services to the elderly and as a family care-giver of a victim of Alzheimer's disease.

Professionally for twenty-two years I have been the executive director of United Methodist Senior Services of Mississippi, Inc., a non-profit organization which provides services to older persons without regard to their race, religious affiliations, or economic circumstances. Presently we are providing services to more than three thousand older persons in almost one-half of Mississippi's eighty-two counties. Many of these services are provided through contracts with various area agencies on aging in the state. We have been involved in providing services under the Older Americans Act continually since 1969. We have had the opportunity to see this program grow through these years and to participate in its maturity. Let me assure you that it is a valuable resource in our area.

But I am also here as a representative of a family in which Alzheimer's disease has had a devastating affect. My brother, Jack, a productive citizen for more than fifty years and a successful insurance agent, was diagnosed as apparently having Alzheimer's five years ago. In the two years before this diagnosis, Jack had shown some indications of personality change, depression, and weight loss. Although he continued to work at his job, he was less and less productive. Finally his firm asked him to move out of his office and to work from his home. This was a humiliating move for Jack and only heightened his depression. His wife and I finally persuaded him to see his doctor and get a thorough check-up. After a lengthy battery of physical and psychological tests the doctors reported that he apparently had Alzheimer's disease. The prognosis for a fifty-two year old victim is for a lengthy period of steady decline with only intermittent periods of relative stability at various levels. For over two years Jack was cared for at home. For more than two years he has been a patient in the skilled nursing facility sponsored by the organization by which I am employed.

While Jack was at home his wife, Sara, served as the primary care-giver. Other family members and friends gave limited assistance. Sara had been an outstanding elementary teacher for many years but was forced to take early retirement in order to care for Jack. This curtailed their income significantly. Soon they had to dismiss the part-time help which they had employed. This loss, plus the physical and emotional drain on the primary care-giver, was devastating.

The day came when Sara had to make institutional arrangements. A shortage of nursing beds in our area is a problem. The number of beds available to Alzhemier's patients is even less. When I worked on the development of a nursing facility for United Methodist Senior Services of Mississippi (UMSSM) and particularly when I planned for services to Alzheimer's patients, I never realized how important it would become for my own family. The cost is very high; but, with the assistance of several family members and friends, the bills are being paid and Sara is struggling to get by.

From my dual perspective let me make some observations and some recommendations. I hope that the committee members and staff will take into account both the years of experience and the personal pain which they represent.

1. The needs of the elderly can best be defined by the elderly themselves. There are too many so-called "experts" (like me!) who are drawing conclusions and making plans for older people without adequate input from elders themselves.

2. The local resources which may be utilized in addressing the needs of the elderly are far greater than

government seems to recognize. These local resources need to be cultivated and encouraged on every hand.

3. Access to the service delivery system is often cumbersome and impersonal. Administrative procedures and paperwork often discourage participation in needed services by the elderly and their families.

4. Services to the rural elderly are difficult and expensive. Mississippi is both rural and poor. Programs which have been designed primarily to meet the needs of the urban elderly are often difficult to adapt to our situation.

5. Access to the services delivery system should not be denied to older persons solely because of their financial resources. NEED is not always defined in financial terms! Oftentimes it is seen in the lack of access to existing services. For example, the present very-low income targeting requirements imposed by HUD regulations are keeping some needy persons from a safe and secure living environment solely because of their income.

6. The programs funded under the Older Americans Act have been a stimulus to local and regional organizations in planning and developing complementary services.

7. The lack of flexibility in the use of funds has often caused locally identified needs to have a lower priority in program development and implementation.

8. Access services (as defined under the Act) and case management ought to be seen as channels to provide more effective services to older Americans. They should not remove the voluntary coordinating and cooperative nature of these programs. They should promote cooperation and coordination between existing community organizations in order to effectively utilize available resources.

From this perspective, I submit the following recommendations:

1. The Older Americans Act should mandate significant input at every level by older persons in the program planning and evaluation process. The Federal Council on Aging should have at least eight elderly persons among its fifteen members.

2. Reauthorize the Older Americans Act for a three-year period without major changes. Provide sufficient funding for OAA programs, particularly Title III community services programs such as congregate and home-delivered meals, homemaker services, etc.

3. Maintain the prohibition against state units and area agencies on aging providing direct services except under the most adverse circumstances.

4. Support the development of innovative local approaches for meeting the needs of the communities elderly, particularly in the development of local long-term care systems.

5. Build safeguards into the case management system which will provide freedom of choice to the beneficiary and the provider while ensuring the provision of quality services and efficient utilization of community services.

6. Support the adequate funding of the Social Services Block Grant, help ensure the fair allocation of funds among competing services and target groups, and reestablish state reporting requirements of essential information on services and participants.

7. Continue the efforts to develop some special approaches through training and demonstration grants on the unique cultural needs of ethnic and racial minority elders.

Thank you for giving me this opportunity to testify at this hearing.

Senator **Matsunaga**. Thank you, Mr. Carroll, for your most moving testimony from your personal experience.

Do you have any questions, Senator Cochran?

Senator **Cochran**. Thank you, Mr. Chairman.

Let me follow up on the recommendations that you suggested for the Committee's consideration. One is to mandate involvement by the elderly in the administration of the program. I think that is an excellent suggestion and I am going to suggest that we include it as an amendment in the Older Americans Act. How would we insure that that input is available to the administrators at the local or State level? I know that we could mandate a certain number of elderly persons to serve on the Federal council, as you suggest, but how would we accomplish that at the local level through provisions of the Older Americans Act?

Mr. **Carroll**. Similar mandates could be made down through the system, I think. I have become conscious, in chairing this Task Force on Older Adult Ministries of my church, of a significant number of older people as a very, very valuable resource in services. They know what they need far better than I do, and we are not giving them nearly the opportunity to be decision-makers in the development of these programs. We can mandate down through the system the participation in meaningful ways, not just lip service, but through membership on various bodies that are making decisions and through some carefully structured input from older persons. You cannot just say you are going to have a hearing and think that you are really going to get that kind of input. It has to be structured I think more carefully than that.

I think that if the framers of the Act will just take a look at how they are now developing the delivery system all the way down to the local level and to what degree older people are specifically involved in planning, then that can be done. If nothing else, mandating that at least a majority at every level be older persons making decisions, and then that they are also involved in the evaluation process that says did this work or did it not, and to what degree was this by, with and for older persons.

Senator **Cochran**. There has been testimony already today about some of the titles to the Older Americans Act, and I think both of you mentioned in your testimony that there is a need for greater flexibility at the local level in determining how the funds authorized under this program are used.

I think that is a good suggestion. I do not know how we write it into the Act and I would appreciate your suggestions about how we do that. Do you have any observations about how we make that happen? I would like to see it happen.

Ms. **Mapp**. Well, I do not like to tell you how to do your business. You know, the Older Americans Act is divided up into III(b), III(C)(1) and III(C)(2), and I can understand that—and the (C)(1) program, which is congregate meals, is the largest program, and I can understand that that is the most visible program, and so there are a lot of legislators who would like to see that remain the largest program, but that is not the largest need and we feel like if we could either combine those or have more flexibility. I think there is a 15 percent flexibility now to move one, you know, from (C)(1) to

(C)(2) or to (B), but if we could have a little more flexibility than that, that would help.

I think also there has been a suggestion that another maybe III(E) be included to add some of these programs like case management, that our State in particular and a lot of other States are mandating that we do case management but yet we are not receiving the funds to be able to do an adequate job of this.

Senator COCHRAN. Mr. Carroll, do you have any reaction to that question?

Mr. CARROLL. I would like to give it a little more thought, Senator, if I could and maybe in writing address the issue.

Senator COCHRAN. That would be very helpful. I am sure we could include your written observations in the record as a part of your testimony. I find that very helpful.

Thank you, Mr. Chairman.

Senator MATSUNAGA. Thank you, Senator.

Ms. Mapp, does IUKA, Mississippi come within the jurisdiction of the Three Rivers Area Agency on Aging?

Ms. MAPP. Yes.

Senator MATSUNAGA. Well, I have a daughter who lives there.

Ms. MAPP. Really?

Senator MATSUNAGA. Yes.

Ms. MAPP. All right. That is a lovely place to live.

Senator MATSUNAGA. Ms. Mapp, if area agencies were to be more active in providing case management services for the elderly population in need of a range of community services, what effect do you think this would have on other area agency responsibilities?

Ms. MAPP. Well, case management is expensive and we only have 8.5 percent in administrative funds, which does not allow for case management. Consequently, we have had to use the other staff or the positions that we had for other staff people to help with the administrative end of the area agency to the case managers. It moved that staff to be case managers, so we are all having to work harder, but that is all right as long as we get the job done. But we do need additional case managers in order to cover our whole area. Right now we have two case managers and we are only covering three of our eight counties.

In the long run, when you first look at it it looks expensive and it is expensive. But when you think about all of the local funds and the volunteers and donated services that these case managers generate, then it is worth it.

Senator MATSUNAGA. Thank you very much.

Mr. Carroll, you spoke about your brother and the experience of his family and yours. Did you at that time or do you presently have any access to any government programs to help with either the cost or the actual provision of care for your brother?

Mr. CARROLL. The only funds that were available and that are still presently available to him were those when he was declared totally and permanently disabled and was able to draw on Social Security even though he had not reached 62 years of age at the time, but those were the only funds.

Senator MATSUNAGA. So, although he had been diagnosed as being afflicted with Alzheimer's, he was not at that point eligible for government assistance?

Mr. Carroll. That is correct, not in the home or in an institutional setting.

Senator Matsunaga. Well, I am sure other Committee members may have questions for you, and, if so, we would appreciate it if you would submit the responses in writing.

Thank you both. As one whose heart is very close to Mississippi, I appreciate you coming. Thank you very much.

Ms. Mapp. Thank you.

Mr. Carroll. Thank you, Senator.

Senator Matsunaga. Our next panel consists of Dr. Mary Howell, who is the Director of the Kennedy Aging Project, Eunice Kennedy Shriver Center, Waltham, MA, who will be testifying on behalf of the Joseph P. Kennedy, Jr. Foundation and the National Association of Protection and Advocacy; and Dr. Carl Eisdorfer, Department of Psychiatry, School of Medicine, University of Miami, who will be testifying on behalf of the American Psychological Association, the American Nurses Association, the American Psychiatric Association, and the National Association of Social Workers.

I understand that Dr. Howell needs to catch a plane, so we will, if you other witnesses do not mind, have the lady first. We would be happy to hear from you, Dr. Howell.

STATEMENTS OF DR. MARY HOWELL, DIRECTOR, KENNEDY AGING PROJECT, EUNICE KENNEDY SHRIVER CENTER, ON BEHALF OF JOSEPH P. KENNEDY, JR. FOUNDATION, NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS; AND DR. CARL EISDORFER, DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, UNIVERSITY OF MIAMI, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, THE AMERICAN NURSES ASSOCIATION, THE AMERICAN PSYCHIATRIC ASSOCIATION, AND THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Dr. Howell. Thank you.

I am a physician, a pediatrician, and I am also a developmental psychologist. I am the Director of the Kennedy Aging Project at the Shriver Center, in Waltham, MA.

The Kennedy Aging Project is sponsored by the Joseph P. Kennedy, Jr. Foundation, and also by the Department of Mental Health of the Commonwealth of Massachusetts. It is charged to educate health professionals about the problems and care of persons who are both mentally retarded and old.

We define health broadly and we include in our project staff, faculty, and students from the fields of medicine, nursing, law, social work, community resource outreach, ministry, clinical psychology, and sports and therapeutic recreation.

I am pleased to be here today to discuss how the needs of this special population can be met by proposed changes in the Older Americans Act. In 1975, Public Law 94-142, which is the Education of All Handicapped Children Act, was passed. This law requires the States to provide free and appropriate public education to all handicapped children. Prior to this time, many children with mental retardation were excluded from schools.

Some children were kept at home by their parents and some children eventually entered large isolated institutions for the retarded.

Those who were kept at home often remained totally unknown to the service system that subsequently developed and were deprived of any needed services. As a result of parental action in the 1950s and 1960s, class action lawsuits in the sixties and seventies, and much State and Federal legislation, many retarded individuals who were in institutions were sent out to return to their families, to move into group home settings as members of communities or—and this is often inappropriate and unfortunate—to move into nursing homes.

In the same time period, comprehensive service systems were developed for younger individuals. It has become obvious that integrating individuals with mental retardation into activities of everyday living of non-handicapped individuals, known as the least restrictive environment or mainstreaming, is the best way to meet the needs of the majority of individuals with mental retardation.

I should say that there are advantages to mainstreaming, both for those who are retarded and also for the rest of society. Mainstreaming should also apply to services for individuals who are elderly and mentally retarded. These persons need access to the full range of services available for all individuals who are aging. We need to respect the right of persons who are elderly and mentally retarded to retire, to enjoy more leisure options, to have safe and secure housing and appropriate health care, and to spend their latter years with a sense of dignity and accomplishment.

The Nation is now confronted with two populations of persons who are retarded and old. The first of these populations is made up of those who have been at home with their parents for all of their lives, with limited or absent education services, vocational guidance services and other social services.

The second is those who were in State schools. Most of these have subsequently been deinstitutionalized. I should add parenthetically that there is also a younger group that we need to plan for who have been involved in mainstream school systems and work programs for much of their lives and are now growing old along with their non-retarded age mates.

For many reasons, some of which I have noted, it is very difficult to get accurate counts of the number of individuals who are old and retarded. On a national scale, estimates range from 200,000 to 500,000 persons. We do know that their number is growing. For this growing number, we need to insure that they are integrated into the service system for other elderly individuals. We need also to train professionals who will provide these services.

Our Kennedy Aging Project is this sort of training program, a demonstration project. We teach our students in the context of providing exemplary services. One such service is a clinic for interdisciplinary team assessment and planning. Our students also carry out valuable research in areas as diverse as an assessment of nursing care needs of clients with Down's syndrome and Alzheimer's disease or an interview protocol for evaluating a person's spiritual well-being and needs, or a will-writing project in which clients with mental retardation are assisted in the mainstreamed or normalized activity of writing their wills.

I believe, based on our experience in Massachusetts and the experience of my colleagues around the country, that minor alterations of the Older Americans Act could improve services to individuals who are old and retarded. I am not suggesting that major shifts of funds be made from current Older Americans Act programs to programs for the mentally retarded.

On the contrary, involvement with programs funded by the Older Americans Act will enrich and contribute to the normalization of the lives of persons who are old and mentally retarded.

Allow me to make suggestions for changes in the Older Americans Act in general terms. First, I would like to place emphasis on two special points. I believe that it is unlikely that professionals will include persons who are both old and retarded among their clientele unless these professionals receive special training.

In addition, I want to point out that, as I have already indicated, there are individuals with mental retardation who live in nursing homes primarily because community placements or group homes are not available for them. At the present time, oversight of the care of individuals in nursing homes is split between protection and advocacy systems for the mentally ill, protection and advocacy systems for persons who are developmentally disabled, and the nursing home ombudsman program. I believe that these various groups pertaining to elderly individuals should be coordinated under the Older Americans Act.

I have attached to my written testimony recommendations for specific changes in legislative language. I would like to summarize these suggestions now.

First, appropriate cross-training should be provided. Mental retardation and development disabilities should be recognized as areas for research and training for professionals in the various fields of gerontology.

Second, State commissioners on aging should be required to consider the needs of individuals with mental retardation and other developmental disabilities in developing their State plans on aging.

Third, it should be required that appropriate national and local organizations representing persons with life-long disabilities, including mental retardation, should be consulted in the development of the State plan on aging.

Fourth, it should be required that written cooperative agreements be developed between State aging agencies and agencies on mental retardation and developmental disabilities.

Fifth, group homes or nursing homes should be recognized as the designated home of the person with mental retardation so that he or she can receive services under the Older Americans Act.

And sixth and finally, activities of protection and advocacy systems for all elderly individuals should be coordinated.

[The prepared statement of Dr. Howell follows:]

TESTIMONY
ON THE
OLDER AMERICANS ACT:

By

Mary Howell, M.D., Ph.D.
Director, Kennedy Aging Project
Shriver Center for Mental Retardation
Waltham, MA 02254

MR. CHAIRMAN, I am Mary Howell, M.D., Ph.D., Director of the Kennedy Aging Project at the Shriver Center in Waltham, Massachusetts, a project sponsored by the Joseph P. Kennedy, Jr. Foundation and the Commonwealth of Massachusetts. I am pleased to be here today to discuss the needs of a special population: older individuals who are mentally retarded. I want to look especially at how those needs might be met by changes in the Older Americans Act.

HISTORICAL PERSPECTIVE ON INDIVIDUALS WHO ARE ELDERLY AND MENTALLY RETARDED

In order to understand the current needs of the population of individuals who are elderly and retarded, we first need to understand some of the history related to this population.

In the first 60-70 years of this century, parents with a very young mentally retarded child had two choices regarding the care of that individual. Either they could send their child to a state institution -- the Willowbrooks and Apple Creeks of this country -- or they could keep their child home with virtually no public services being available.

Prior to 1975 when PL 94-142 (The Education of All Handicapped Act) was passed requiring the state to provide a free and appropriate public education to all handicapped children, many such children were excluded from school. If, for example, a child showed some difficulty in kindergarten or the primary grades an IQ test would be administered. If the child scored below 50 on this single test, the parents would be advised that the child was exempt from the compulsory school attendance laws, and, moreover, that the school had no program to meet the child's needs. Therefore, parents kept their children at home, and some of the children eventually entered state schools for the retarded. Those kept at home often remained totally unknown to the service system that subsequently developed.

As a result of parental action in the 1950's and 60's, class action law suits in the 60's and 70's and much state and federal legislation, many retarded individuals who were in institutions have been sent out to return to their families, to move into group home settings, or, unfortunately and often inappropriately, to move into nursing homes. Over the same time frame, service systems have developed for younger individuals; and it has become obvious that integrating individuals with mental retardation into environments with non-handicapped individuals -- known as "the least restrictive environment" or mainstreaming -- is the best way to meet the needs of the majority of individuals with mental retardation.

The nation is now confronted with two populations of elderly individuals who are retarded. The first is those who have been at home with their parents for all of their lives with limited or absent education services, vocational guidance services and other social services. The second is those who were in state schools and who have subsequently been deinstitutionalized. In addition, there is a younger group that we need to plan for who have been involved in mainstream school systems and work programs for much of their lives and who are aging along with the bulk of the current population.

THE SCOPE OF THE PROBLEM OF INDIVIDUALS WHO ARE ELDERLY AND MENTALLY RETARDED

Because of the problems noted above, getting accurate counts of the number of individuals who are elderly and retarded is very difficult. On a national scale, estimates range from 200,000 to 500,000 individuals who are 60 and above and who are developmentally disabled. The majority of those individuals are mentally retarded.

To look at this issue another way and to emphasize how many of these individuals may be unknown to the service system, let me review some of the data that have been collected in two counties in Ohio. Nationally, it is estimated that from 1 1/2 to 3 percent of the population are mentally retarded. Based on that estimate, in Stark County with an over-60 population of 60,000 there may be as many as 900 individuals who are elderly and retarded. There are only 65 individuals over-60 in the programs of the County Board of Mental

Retardation and Developmental Disabilities. In Summit County, with an over- 60 population of 84,000, there may be as many as 1200 individuals who are elderly and retarded; but only 140 are in County Board Programs.

In another study, data were collected on the characteristics and life status of 97 mentally retarded/developmentally disabled persons over sixty. Three-fourths of them were moderately to mildly retarded, i.e., those who need some supervision in daily activities to those needing very little. Generally, the individuals were able to communicate, were free of maladaptive behaviors and had physical health status comparable to similarly aged individuals in the general population. Their academic and social skills were limited and, in general, they did not use community services available to older adults. In the population studied, about three-fourths lived in group homes or nursing homes, and the remainder lived with their families or alone.

THE KENNEDY AGING PROJECT AND OTHER DEMONSTRATION PROJECTS SPONSORED BY THE JOSEPH P. KENNEDY, JR. FOUNDATION TO MEET THE NEEDS OF INDIVIDUALS WHO ARE ELDERLY AND MENTALLY RETARDED

With the growing numbers of individuals who are aging and retarded, the country needs to ensure that they are integrated into the service system for other elderly individuals, where necessary, develop service systems to meet their special needs, and to train individuals to provide these services.

At the Shriver Center in Waltham, Massachusetts we have developed a model system that delivers some of the specialized services required by individuals who are elderly and retarded and provides training for professionals who will work in the aging and developmental disabilities systems. Building on the model of interdisciplinary training of staff and interdisciplinary evaluation and management of children with developmental disabilities, we have developed a program for health and social assessment of individuals who are elderly and mentally retarded. In our multiphasic screening and intervention program evaluates clients are evaluated by professionals in the areas of medicine, nursing, social work, community mental health, clinical psychology, law, community resources, ministry, and sports and therapeutic recreation.

Training of graduate students in each of these disciplines is an integral part of our activity. In addition to the training that they have received, our students have performed valuable research in areas as diverse as "An Assessment of Health Care Needs of Clients with Down Syndrome and Alzheimer's Disease" to "Assisting Clients with Mental Retardation Write Wills".

In addition to the work of the Kennedy Aging Project, the Kennedy Foundation is also sponsoring a cross-disciplinary training project at the University Center on Aging at the University of Massachusetts Medical Center in Worcester, Massachusetts. There, medical students and Family Practice Residents are given training in the health care needs of elderly individuals who are retarded, and students in the baccalaureate Certificate Program in Gerontology are taught about the needs of elders with developmental disabilities.

Mainstreaming is a term that has been applied to when children who are mentally retarded or developmentally disabled are taught in regular school classrooms to the greatest extent possible. It is also a term which should be applied to individuals who are elderly and mentally retarded. These persons need access to the full range of services available for all individuals who are aging. We need to respect the right of persons who are elderly and mentally retarded to retire, to enjoy more leisure options, and to spend their latter years with a sense of dignity and accomplishment.

At the Kennedy Access Project in Akron, Ohio a system of matching elderly individuals without handicaps with elderly individuals who are retarded has been developed. The non-handicapped individuals assist their friends by introducing them to community activities such as nutrition centers for elders and senior center programs. The non-handicapped person, by becoming personally involved with their friends, increase the retarded individual's communication and social skills.

Some of the activities of the Access Program have been carried out using programs funded by Area Offices on Aging through the Older Americans Act. In cooperation with Area Agencies on Aging, funds from Title IV were used to support cross-disciplinary educational programs for state aging and developmental disabilities staff. Some of the senior citizens who work with the individuals who are retarded are volunteers, coming from church and synagogue groups, and Retired Senior Volunteer Programs (RSVP). Others are individuals hired using funds from Title V of the Older Americans Act to work with the older retarded individuals.

I believe, based on our experience in Massachusetts and the experience of my colleagues around the country, that minor alterations of The Older Americans Act could improve services to individuals who are old and retarded. I am not suggesting that major shifts of funds be made from current Older Americans Act programs to programs for the mentally retarded. Involvement with Older Americans Act programs will enrich and contribute to the normalization or mainstreaming of the lives of persons who are older and mentally retarded.

In making suggestions for changes in the Older Americans Act, there are two points that I wish to emphasize. First, I am especially concerned with the need for health professionals to be trained to work with patients or clients who are old and retarded. This training has been sadly neglected in the past, and should be greatly bolstered in the future. Second, as I indicated above, there are individuals with mental retardation who are in nursing homes, primarily because community residency placements are not available. At the present time, oversight of the care of individuals in nursing homes is split between Protection and Advocacy Systems for the Mentally Ill, Protection and Advocacy Systems for Persons who are Developmentally Disabled and the Nursing Home Ombudsman Program. I believe that the services that these various groups provide to elderly individuals should be coordinated under the Older Americans Act.

Recommendations for specific changes in legislative language can be found in Appendix I of my written testimony. In general, I suggest that:

1) Appropriate cross-training be provided and that mental retardation and developmental disabilities be recognized as an area for research and training for gerontology professionals.

2) State Commissioners on Aging be required to consider the needs of individuals with mental retardation and other developmental disabilities in developing the state plan on aging.

3) It be required that appropriate national and local organizations representing persons with lifelong disabilities including mental retardation be consulted in the development of the state plan on aging.

4) It be required that written cooperative agreements be developed between state aging and mental retardation/ developmental disabilities agencies.

5) Group homes and, where group homes are unavailable resulting in individuals with mental retardation living in nursing

homes, nursing homes be recognized as "the home" of persons with mental retardation so that they can receive services under The Older Americans Act.

6) Coordinate the activities of Protection and Advocacy Systems for all elderly individuals.

In summary, let me say that when I talk about that group of persons who are both mentally retarded and old, I am talking about a small but growing group of individuals. We need to increase the number of professionals with training in the combined fields of geriatric and mental retardation/ developmental disabilities. We need to increase the participation of individuals who are aging and mentally retarded in programs developed for all Americans who are aging, a task that can be accomplished without detracting from services to individuals who are not retarded. We need to coordinate the activities of Protection and Advocacy Systems for all elderly individuals. Most of the suggestions that I have made are no-cost or low-cost. I believe that the inclusion of the person who is aging and mentally retarded into the mainstream of services for the average aged individual is the natural extension of the normalization process now extended to school aged individuals who are retarded. This is something that we should do for this long invisible and neglected population.

Thank you.

APPENDIX I

Suggested Legislative Language

DISCUSSION DRAFT

SUGGESTED CHANGES TO PL 98-459 (OLDER AMERICANS ACT) TO ACCOMMODATE NEEDS OF GROWING POPULATION OF OLDER DEVELOPMENTALLY DISABLED PERSONS

CHANGES TO TITLE II

1. That Sections 202(a) and 202(b)(1) of Title II be amended to include a requirement that the Commissioner consider the needs of older persons with life-long disabilities and develop additional planning linkages with developmental disabilities planning councils.

The amendment to Section 202(b)(1) of Title II would read as follows:

"(1) develop planning linkages with health system agencies designated under Section 1515 of the Public Health Service Act (42 U.S.C. 300 1-4) [and], with utilization and control peer review organizations under title XI of the Social Security Act, and with state developmental disabilities planning councils designated under Section 124(a)(1) of the Developmental Disabilities Act;

It is proposed that Section 202(b) be amended and that a new subection (19) be added. The amendment to Section (b) would read as follows:

"(19) consult with national organizations representing the interests of older individuals with life-long disabilities or impairing conditions, such as mental retardation and developmental disabilities, to develop and disseminate information on population characteristics and needs, training of personnel, and to provide technical assistance designed to assist State and area agencies to provide services in collaboration with other State agencies to older persons with life-long disabilities.

CHANGES TO TITLE III

2. That Section 305(a)(2) of Title III be amended to include a provision that the State agency designated under clause (1) of Section 305(a) provide assurances that it cooperate and collaborate in planning and provision of services with other State agencies (whose primary responsibilities are for individuals with mental retardation, developmental disabilities, or other life-long handicapping conditions) for those older mentally and physically disabled individuals determined to have special needs; and that Section 307(a) of Title III be amended to include a requirement that the state aging plans are developed in cooperation with state devlopmental disabilities planning councils and state mental retardation/developmental disabilities agencies.

It is proposed that a new subsection (F) be added to Section 305(a)(2). The amendment to Section 305(a)(2) would read as follows:

(E) provide assurances that cooperative arrangements will be developed with state and area agencies with primary responsibility for individuals with mental retardation, developmental disabilities, or other life-long handicapping conditions, and provide for collaborative programs to meet the needs of vulnerable older individuals with mental retardation, developmental disabilities, or other life-long handicapping conditions.

3. That Section 307(a) of Title III be amended to include a requirement for assurances that the State will cooperatively plan and provide for in-service training, and collaborate on the provision of services for individuals with mental retardation, developmental disabilities, or other life-long handicapping conditions. Such cooperation and collaboration would be carried out with the lead State agency responsible for such persons.

It is proposed that a new subsection (18) be added to Section307(a) and that sections (18), (19), (20), and (21) of Section 307(a) be renumbered to be (19), (20), (21), and (22). The amendment to Section 307(a) would read as follows:

(19) provide with respect to the needs of older persons with mental retardation or other developmental disabilities (as defined in Section 102(7) of the Developmental Disabilities Act of 1984) that the plan provide assurances that each State will

cooperatively plan and provide in-service training and collaboratively provide for services for older persons with life-long handicapping conditions, such as mental retardation and developmental disabilities; and that--

(A) coordination of planning occurs with the state developmental disabilities planning council designated under Section 124(a)(1) of the Developmental Disabilities Act; and

(B) coordination of planning, enumeration, assessment of needs, and service provision for older persons with developmental disabilities occurs with the State mental retardation/developmental disabilities agency.

CHANGES TO TITLE IV

4. That section 401 of Title IV be amended to include a reference to special needs older individuals in respect to the purpose of the title.

It is proposed that Section 401 be amended and that current items (3) and (4) be renumbered to be items (4) and (5) and a new item (3) be included in the listing of purposes to read as follows:

"(3) collaborative projects joining aging with fields specializing in disability and special-need populations; and

5. That a new Section 413 be added to Part A of Title IV to include a provision that would enable the Commissioner to enter into cooperative agreements with the Commissioner of the Adminiministration on Developmental Disabilities in order to establish education and training programs in aging and developmental disabilities. The Commissioners, jointly, would be authorized to make grants to public and private nonprofit agencies, organizations and institutions for the support of multidisciplinary centers that would train personnel to work with older individuals with mental retardation and developmental disabilities.

It is proposed that a new Section 413 be added that would read as follows:

"Sec. 413. (a) The Commissioner in agreement and conjunction with the Commissioner of the Administration of Developmental Disabilities may make grants to private and public nonprofit agencies, organizations, and institutions of higher education for the purpose of establishing multidisciplinary centers in aging and developmental disabilities. Such centers shall conduct research and policy analysis, provide for the training of personnel, serve as a technical resource at the state level for state units on aging, state developmental disabilities planning councils, and state mental retardation/developmental disabilities agencies and at the national level to the Commissioners and the Congress, and provide for other functions deemed necessary by the Commissioner. Such centers on aging and developmental disabilities shall--

(1) develop and provide education programs for the training of personnel working with older developmentally disabled individuals;

(2) conduct research on service practices;

(3) provide technical assistance to State and area agencies providing for older individuals with developmental disabilities; and

(4) serve as repositories of technical information.

"(b) A grant may be made under this subsection to fund a program proposed to be operated jointly with a university affiliated program in developmental disabilities as defined by section 152 of the developmental disabilities act.

CHANGES TO TITLE V

6. That Section 412(a) of Title V, Part A, be amended to include a reference that grants awarded to multidisciplinary centers include special emphasis on disability.

It is proposed that Section 412(a) be amended to read as follows:

"Sec. 412(a) The Commissioner may make grants to public and private nonprofit agencies, organizations, and institutions for the purpose of establishing or supporting multidisciplinary centers of gerontology, and gerontology centers of special emphasis (including emphasis on nutrition, disability, employment, health, income maintenance and supportive services). Such centers shall conduct research and policy analysis and function as a technical resource for the Commissioner, policymakers, service providerws, and the Congress. Multidisciplinary centers of gerontology shall--

APPENDIX II

Bibliography Specific to Older Adults
with Developmental Disabilities

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Senator MATSUNAGA. Thank you very much, Dr. Howell. We have a vote on now, and have only a few minutes left before I need to go, Dr. Eisdorfer. It is rough testifying before a Senate committee, especially when we have so many votes being taken on the floor at the same time. We will be happy to hear from you, Dr. Eisdorfer.

Dr. EISDORFER. Thank you, Mr. Chairman.

I am Carl Eisdorfer. I am Professor and Chairman of Psychiatry and Professor of Psychology at the University of Miami. I also direct the university's Aging Center and I am Director of our Center on Alzheimer's Disease and Memory Disorders.

I am honored to be here today to speak to you on behalf of four major organizations, the American Nurses Association, the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers, to discuss the reauthorization of the Older Americans Act.

A detailed description of our recommendations as well as the justification has already been submitted for the record so I will not restate it here.

Our primary concern is the need for a coordinated approach to the delivery of mental health and social services to older persons in the community. As the Subcommittee develops its amendments to the Older Americans Act, we urge that the needs of older persons with mental disorders and other severe impairing conditions become a priority issue.

We believe that the Act can and should serve as a legislative foundation for programs designed to reach many of the Nation's elderly in need, in dire need, I must say, of improved mental health and social services.

Before presenting in summary our recommendations, I would like to describe the populations who need help and to point out some of the obstacles currently impairing our ability to deliver help.

While most older persons are emotionally healthy, it is currently estimated that between 10 to 28 percent of older Americans living at home or in the community, between 2.5 and 7.5 million individuals, have mental disorders serious enough to warrant professional attention. Sadly, it is also estimated that over 80 percent of the elderly in need of such services do not receive them and, in fact, will not receive them.

Older persons with mental disorders differ from other age groups in that they are much more likely to have multiple disorders, to have overlapping and interdependent medical, social, behavioral, and mental problems which require attention and coordination of different service systems as well as different kinds of providers. They are a hetereogeneous group, but I think we can broadly define them into four categories. Each category represents different service needs.

The first group are those with a long-standing history of chronic mental impairments who reach old age. Many of these individuals were once residents of State psychiatric hospitals but, because of the nature of Medicaid and Medicare legislation, were transferred to nursing homes and board and care facilities during the deinstitutionalization movement which began in the 1960s. We now know that a substantial portion of 1.5 million Americans in nursing homes and other long-term care facilities have serious mental and emotional disorders but receive little by way of appropriate care.

More recently are those who never obtained admission to a State hospital and may be counted among America's tragic homeless population.

The second category includes those older persons who developed mental disorders in later life for the first time. The predominant orders include depression, severe anxiety, a high suicide rate (particularly among older men) and dementia. Persons in this category are more likely to reside in home or in the community and be cared for by families, often creating a substantial burden of care, as I know you are aware, Mr. Chairman.

The third category include those with mental disorders associated with physical health disorders. Examples of problems in this category include severe anxiety, which can be crippling, associated with cardiac disease; strokes and depression; gastrointestinal disease and cancer; and as hearing loss and paranoia.

A fourth category involves a very important problem, often not recognized, the exacerbation of physical problems by underlying emotional disorders. It is clearly reflected by the important role of antidepressants and/or behavioral techniques in alleviating chronic pain and of psychotherapy in reducing the costs of general health care, not just psychiatric care.

In addition to the four categories I mentioned, many older persons could benefit from mental health services directed at helping them cope with stressful living conditions, social isolation, bereavement, and enormous demands of serving as a caregivers to a severly impaired family member.

In a study which we completed, more than half of family care givers lived with Alzheimer's patients were clinically depressed by psychiatric standards. Research and clinical experience have demonstrated that older persons respond very well to appropriate psychotherapeutic, psychopharmacologic, behavior and social interventions, and that these interventions can be readily and effectively provided on an outpatient basis. Unfortunately, the aged rarely receive the mental health care they need.

Community mental health centers are the major publicly funded mental health system in this country and yet they are meeting the needs of only a few elderly. The mental community health centers report that approximately 6 percent of their caseload are elderly, despite the fact that the elderly represent 12 percent of the population and in excess of a third of all of the hospital in-patient beds. While some centers provided superb services to the aged, many serve almost no elderly.

Older persons are under-represented throughout the mental health delivery system, including private mental health practice and nursing homes.

This is a serious situation. At a time when there are more older persons in need of services, the level of care available is declining. This situation needs to be reversed.

Inadequate service to the elderly persists as a result of a combination of factors: reimbursement structures under Federal health programs; the severe reduction of Federal health funding under the Alcohol, Drug Abuse, and Mental Health Services block grant; the continued fear and stigma that stil haunt our conception of mental disorders; and the disorganized and fragmented system of mental health, physical health, and social services for the elderly.

It is sad commentary that today's Medicare system fails to assure that older persons receive adequate and necessary mental health care. We commend Chairman Matsunaga for introducing S. 718, to eliminate some of the gaps in Medicare reimbursement for outpatient mental health care.

The Subcommittee can help make a difference in another area which serves to segregate the elderly with mental and emotional problems from the health care and social service networks. Due to the financial problems and the stigma often attached to mental illness, and due to their private fears relating to it, many older people and their families are reluctant to seek mental health care. We believe that it is essential that mental health and aging services organizations work together to eliminate the myths and stigma of mental illnesses by placing them in their proper perspective, namely that mental disorders have multiple causes and can be ameliorated and treated in the same way as physical disorders. The existing network of area agencies on aging established under the Older Americans Act can help bridge the gap between the myths surrounding mental disorders and the realities of modern mental health care, and provide the link and access to both the mental health and aging services systems.

The fragmentation of services to older persons is a major factor contributing to the under-service of the aged, but one that can be addressed by the Older Americans Act. As the Subcommittee is aware, there are two distinct service systems, community mental health centers and services financed by Area Agencies on Aging, which can potentially serve the psychosocial needs of the older person. Unfortunately, these systems are currently structured as separate, independent systems. There is currently little routine interaction and almost no cooperation in service delivery between the two service systems. Community mental health centers and area agencies on aging are well aware of the mental health needs of the aged, and believe there should be more cooperation between the two services networks in the delivery of needed integrated services. The amendments we are proposing to the Older Americans Act address the need for cooperation and interaction between the mental health and aging service systems at the Federal, State, and local levels.

We are confident that these recommendations are an efficient and cost-effective means of improving mental health care for the elderly. In summary, we recommend:

First, that Functions of the Commissioner, under Title II of the Act, be amended to include providing assistance in the establishment and implementation of programs to meet the needs of older individuals for mental health services and address the needs of older persons with such severely impairing conditions as developmental disabilities, stroke, physical and sensory impairment, and mental disorders.

Second, the Title III of the Act be amended to:

(a) Encourage the development of cooperative working agreements between State agencies and State departments of mental health and between area agencies on aging and local community mental health centers in meeting the mental health and social service needs of the elderly.

(b) Encourage the development of cooperative working agreements between State and area agencies with other State agencies whose primary responsibilities are for individuals with mental retardation, developmental disabilities, or other handicapping conditions.

(c) Assure that area and State plans include mental health services and address the needs of older persons with severely impairing conditions.

Third, that the Act be amended to:

(a) Include reference to older persons with special needs, such as disabilities and mental disorders (including Alzheimer's disease and related disorders), in all relevant sections.

(b) Make grants available for the training of Title III service providers and nursing home care providers to meet the special services needs of elderly with mental disorders, and other severely impairing conditions.

We believe that these recommendations can be implemented under the existing resources of the Older Americans Act. As these recommendations encourage planning and coordination efforts between agencies and departments, and allow for competition for grant awards, they do not require a redirection of the Older Americans Act resources or an additional appropriation for implementation. We are, however, most supportive of the Older Americans Act budget increases recommended by other groups, and believe that the valuable services provided by the Act should be expanded to meet the poorly met needs of additional older persons.

We thank the Subcommittee for the opportunity to express our views on the Older Americans Act. We will continue to support this Subcommittee's efforts to improve the care of this nation's older population. We would be pleased to work with the Subcommittee in developing the amendments necessary to carry out these recommendations. I will be happy to respond to any questions that the Subcommittee may have.

Senator **Matsunaga**. Dr. Eisdorfer, I am sorry, I must leave now or I will miss the vote. I may have already missed the vote, but I will have to run over to the floor. Your entire statement will appear in the record as though presented in full.

[The prepared statement of Dr. Eisdorfer follows:]

TESTIMONY OF

Carl Eisdorfer, Ph.D., M.D.

on behalf of

AMERICAN NURSES' ASSOCIATION

AMERICAN PSYCHIATRIC ASSOCIATION

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

to the

U.S. SENATE, COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON AGING

Hearing on the "Reauthorization of the Older Americans Act"

March 31, 1987

The Honorable Spark M. Matsunaga, Chairman

On behalf of the American Nurses' Association, the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers, I am pleased to present this testimony before the Senate Labor and Human Resources' Subcommittee on Aging hearing on "The Reauthorization of the Older Americans Act." We welcome this opportunity to comment on the mental health care needs of older Americans.

The American Nurses' Association (ANA), comprising 53 state and territory constituent members, is the national professional organization representing the interests of the nation's professional nurses. The purposes of the ANA are to work for the improvement of health standards and the availability of health care services for all people; to foster high standards of nursing; and to stimulate and promote the professional development of nurses and advance their economic and general welfare.

The American Psychiatric Association is the nation's oldest medical specialty society, representing over 33,000 psychiatrists nationwide. The objectives of the Association include: improving the treatment, rehabilitation, and care of the mentally ill, mentally retarded, and emotionally disturbed; fostering cooperation of all who are concerned with the medical, psychological, social, and legal aspects of mental health and illness; and promoting the best interests of patients and those actually or potentially making use of mental health services.

The American Psychological Association, representing over 87,000 members, is the nation's major psychology organization. The Association works to advance psychology as a science, a profession, and a means of promoting human welfare by promoting responsive concern by the profession on a variety of social and public policy issues; disseminating psychological knowledge to enhance and increase human progress and well-being; developing standards of education, ethical conduct, and professional practice; promoting research; and improving research methods and conditions.

The National Association of Social Workers (NASW) is the largest organization of professional social workers in the world, with over 102,000 members nationwide. The primary objectives of NASW include: promoting the quality and effectiveness of social work practice; improving social conditions through the utilization of professional knowledge and skills; and providing opportunities to work toward alleviating or preventing deprivation, distress, and strain through social work practice and social action.

Our primary concern is the need for a coordinated approach to the delivery of mental health and social services to older persons living in the community. As the Subcommittee develops its amendments to the Older Americans Act, we urge that the needs of older persons with mental and behavioral disorders, and other severly impairing conditions, become a priority issue. We believe the Act can, and should, serve as a legislative foundation for programs designed to reach many of the nation's elderly in need of information about, and access to, mental health and social services. However, before detailing our recommendations and concerns in this regard, we believe it is important to describe the populations with whom we are most concerned, and to point out some serious obstacles to meeting the care needs of these populations.

Mental Health Needs of Older Persons: Background

While most older persons are emotionally healthy individuals, it has been estimated that 10% to 28% of older Americans living in the community (2.6 to 7.3 million individuals) have mental disorders serious enough to warrant professional attention. Unfortunately, it has also been estimated that over 80% of the elderly in need of mental health services will not receive them.

Older persons who are in need of mental health services are a heterogenous population, but may be grouped into three broad categories. These categories represent different etiological factors for the mental disorders and may represent different service needs. First, individuals with a history of chronic mental impairment who have reached old age. The predominant mental disorders of persons in this category include: schizophrenia, severe depression, severe character disorders, and chronic addictive disorders. Many of these individuals were once residents of state psychiatric hospitals, but were transfered to nursing homes and board and care facilities during the deinstitutionalization movement begun in the 1960s. Some have become homeless persons. These older individuals are sometimes participants in senior centers and nutritional sites.

The second category includes older persons who develop mental disorders in later life, with no prior history of impairment. The predominant disorders in this category include anxiety disorders, dysporia and major depression, a high suicide rate (men over the age of 75 have the highest rate for all age groups), social withdrawal, poly drug use and misuse (and confusion about) prescription drugs, alcohol abuse, organic brain syndrome, and dementia (including Alzheimer's disease). Persons in this category are more likely to reside in the community and be cared for by their family.

The third category includes individuals with mental disorders associated with physical health disorders. Examples of disorders in this category include severe anxiety associated with gastrointestinal complications, hearing loss that may lead to delusions and social withdrawal, and cardiac disease and depression. The interaction between mental disorders and physical illness in the elderly is only beginning to be understood, and is a focus of continuing research.

In addition to the three categories noted here, many mental health professionals believe that older persons could benefit from mental health services directed at helping them cope with circumstances that may contribute to the development of mental disorders, such as stressful living conditions, social isolation, bereavement, and the demands of serving as a caregiver to a severely impaired family member.

Older persons with mental disorders differ from other age groups in that they are more likely to have multiple comorbidities. The aged may have overlapping and interdependent medical, social, behavioral, and mental problems, requiring the attention and coordination of service systems as well as service providers.

Underservice of Older Persons With Mental Disorders

Research and clinical experience has demonstrated that older persons do respond well to appropriate psychotherapeutic, psychopharmacological, behavioral, and social interventions, and that these interventions can be effectively provided on an outpatient basis. But, unfortunately, it has been estimated that over 80% of those aged in need of mental health services do not receive them. This is true for both our public and private mental health systems.

Under the current federally initiated service system, community mental health centers (CMHCs) are the designated community agencies providing mental health services to older adults, as well as to younger populations. Yet CMHCs are meeting the needs of only a few of the elderly. The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging conducted nationwide surveys and site visits, in 1983 and 1985, to determine the quality of services being delivered to older persons by CMHCs and the level of coordination between CMHCs and area agencies on aging in service delivery. Their report, Mental Health Services for the Elderly, documented that although the aged comprise 12% of our national population, they comprise an average of only 6% of the CMHC clinical population. While some centers provide superb services to the aged, many serve almost no elderly. The Action Committee report further documents a deteriorating trend in the number of services for the elderly, a decrease in the number of staff trained to deliver geriatric services, and a decline in outreach programs to locate elderly in need of services.

Older persons are underserved throughout the mental health delivery system, including private mental health practice and nursing homes. Overall, private practitioners provide only 3% of their services to older clients, and fewer than 1% of nursing home residents have access to mental health assessment and treatment.

This is a serious situation for the elderly. At a time when there are more older persons in need of services, the level of care available is declining. This situation needs to be reversed. The associations represented here today are greatly concerned about the lack of adequate mental health services for our nation's older adults.

Factors Contributing to Underservice

The pattern of underservice to the elderly persists as a result of a combination of factors: reimbursement structures under federal health programs; a reduction of federal mental health funding under the Alcohol, Drug Abuse, and Mental Health Services block grant; the continued fear and stigma that still haunt our national conception of mental disorders; and the fragmented, disorganized system of mental health, physical health, and social service programs for the elderly. While we recognize that several of these issues do not fall within the Subcommittee's jurisdiction, we believe an overview of the problems is essential to an understanding of the impediments to mental health care for older Americans.

Federal Reimbursement System

In considering federal reimbursement systems for those with mental disorders, it is a sad commentary that today's Medicare system fails to assure that older persons receive adequate and necessary mental health care. It is important that this Subcommittee, as well as the Finance Committee, become aware that Medicare has institutionalized the bias against those suffering from nervous and mental disorders through its discriminatory coverage of mental health benefits. Medicare Supplementary Medical Insurance (Part B), an optional program for the elderly, has an outpatient mental health benefit which contains numerous disincentives for choosing the most cost effective site for services. Reimbursement is limited to $250 annually, and is based on a formula which effectively requires a 50/50 co-payment by the patient, in contrast to the 20% co-payment for the cost of physical health care. This imposes a significant burden for the older patient, who is less likely to have additional insurance coverage for such services. Medicare also restricts services to older persons in need of inpatient treatment by placing a lifetime limit for inpatient care of 190 days in a psychiatric hospital. These burdensome restrictions serve to severely constrain both outpatient and inpatient treatment of older persons. Medicare's failure to provide adequate coverage for the treatment of mental disorders is not within the purview of the Subcommittee. However, we believe it is important that the Subcommittee recognize that this barrier to adequate health care for the elderly with mental disorders stands in the way of many of our mutual goals.

The Alcohol, Drug Abuse and Mental Health Services Block Grant

Enacted in 1981 under the Omnibus Budget and Reconciliation Act, the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant reflects the Administration's philosophy of decreasing federal service funding and reducing the direction given to states on program priorities. The amount of federal funding for community mental health services under the ADMS block grant has been severely reduced over the past six years and has resulted in a decline in services to older persons. Concurrent with the 1983 implementation of the block grant was an immediate 25% decrease in federal expenditure for alcohol, drug abuse, and mental health services. Between 1981 and 1987 there was a $54 million budget decrease, from $549 million to $495 million, which was compounded by a 17.4% increase in the inflation rate during the same time period. The substantial decrease in federal funding under the ADMS block grant has placed considerable pressure on states to increase their mental health budgets. And while states have generally provided more mental health funding, the increases have barely kept pace with the rate of inflation. As a result, public funded mental health services have decreased in many areas, and the aged remain an underserved population within the community mental health system.

Stigma of Mental Disorders

The Subcommittee can help make a difference in another area which serves to segregate the elderly with mental and emotional problems from the health care and social services networks -- the continuing stigma of mental illness. Due to the stigma often attached to mental illness, and due to their private fears relating to it, many people are reluctant to seek mental health care. Indeed, the person with mental disorders is more likely to delay or reject treatment for their complaint than they would be to seek help for a physical disorder. The erroneous belief often persists that "senility" and "mental decline" are a normal part of aging, that older people naturally grow more pessimistic, rigid, and irascible with age. We believe that it is essential that mental health and aging services organizations work together to eliminate the myths and stigma of mental illness by placing it in its proper perspective, namely that mental disorders can be ameliorated and treated in the same way as many physical difficulties. The existing network of area agencies on aging established under the Older Americans Act can help bridge the gap between the myths surrounding mental disorders and the realities of modern mental health care, and provide the link and access to both the mental health treatment and aging services networks.

Fragmented Service Systems

Although most of the factors contributing to the underservice of the aged are beyond the scope of the Older Americans Act, one of the issues that can be addressed by the Act is the fragmentation of services to older persons. As the Subcommittee is no doubt aware, there are currently two distinct service systems, community mental health centers and services financed by area agencies on aging, which can potentially serve the psychosocial needs of the older person. Unfortunately, these systems are currently structured as separate, independent systems. The community mental health centers serve only the mental health needs of the individual and the area agencies on aging serve only the social services and nutritional needs of the aged. A 1982 study by the U.S. General Accounting Office, The Elderly Remain in Need of Mental Health Services, found that "many of the services which the mentally at-risk elderly need are social supports, rather than, or in addition to, more traditional mental health interventions." In order to improve service delivery to older persons, the authors of the study called for increased cooperation among primary care, mental health, and social service providers. The Action Committee report, cited earlier, supported the GAO findings, documenting that there is little routine interaction and almost no cooperation in service delivery between the two service systems. However, the Action Committee study also found that community mental health centers and area agencies on aging are well aware of the mental health needs of the aged and believe there should be more cooperation between the mental health and aging services networks in the delivery of needed services. Such findings pose a major challenge to both the aging network and the mental health care system. The amendments we are proposing to the Older Americans Act address the need for cooperation and interaction between the mental health and aging service systems at the federal, state, and local levels.

Recommendations for Amendments to the Older Americans Act

The groups endorsing this testimony believe that the Older Americans Act needs to be strengthened to provide older adults greater access to mental health and social support services. In developing these recommendations we have collaborated with a wide range of aging planning and services organizations, aging constituent organizations, national mental health organizations, disability and rehabilitation organizations, and professional associations. We are confident that these recommendations are a cost effective means of improving mental health care for the elderly. In summary we recommend:

First, that Functions of the Commissioner, under Title II of the Act, be amended to include providing assistance in the establishment and implementation of programs to meet the needs of older individuals for mental health services and address the needs of older persons with such severely impairing conditions as developmental disabilities, stroke, physical and sensory impairment, and mental disorders (including but not limited to Alzheimer's disease and related disorders). As older persons with severely impairing conditions, including mental disorders, have often been overlooked in service planning, we believe the Commissioner should give particular attention to addressing their needs.

Second, that Title III of the Act be amended to:

a. Encourage the development of cooperative working agreements between State Agencies and State Departments of Mental Health and between Area Agencies on Aging and local Community Mental Health Centers in meeting the mental health and social service needs of the elderly.

b. Encoruage the development of cooperative working agreements between State and Area Agencies with other State agencies who primary responsibilities are for individuals with mental retardation, developmental disabilities, or other handicapping conditions.

c. Assure that Area and State plans include mental health services and address the needs of older persons with severely impairing conditions.

Third, that Title IV of the Act be amended to:

a. Include reference to older persons with special needs, such as disabilities and mental disorders (including Alzheimer's disease and related disorders), in all relevant sections.

b. Make grants available for the training of Title III service providers and nursing home care providers to meet the special service needs of elderly with mental disorders, and other severely impairing conditions, who are residing either in the community or in nursing care facilities.

Finally, we believe that these recommendations can be implemented under the existing resources of the Older Americans Act. As these recommendations encourage planning and coordination efforts between agencies and departments, and allow for competition for grant awards, they do not require a redirection of Older Americans Act resources or an additional appropriation for implementation. We are, however, supportive of the Older Americans Act budget increases recommended by other groups, and believe that the valuable services provided by the Act should be expanded to meet the needs of additional older persons.

We thank the Subcommittee for the opportunity to express our views on the Older Americans Act. We will continue to support this Subcommittee's efforts to improve the care of this nation's older population. We would be pleased to work with the Subcommittee staff in drafting the final amendments and report language necessary to carry out these recommendations.

Senator **Matsunaga**. Thank you Dr. Eisdorfer, and thank you, Dr. Howell.

[Additional material supplied for the record follows:]

Consortium for
Citizens with
Developmental
Disabilities

April 6, 1987

Senator Matsunaga
Subcommittee on Aging, Committee on
Labor and Human Resoruces
109 Hart Senate Office Building
Washington, DC 20510
(ATTN: Lois Fu)

Dear Senator Matsunaga:

We are enclosing for your consideration a statement by the Consortium for Citizens with Developmental Disabilities (CCDD), Task Force on Aging detailing recommendations for proposed changes to the Older Americans Act in the 1987 reauthorization. We request that this statement be included in the record for the hearing on the Act which was held by the Subcommittee on March 31, 1987.

The CCDD consists of over fifty national organizations that represent the interests of persons with developmental disabilities. It is estimated that there are 200,000 to 500,000 Americans over the age of sixty who have developmental disabilities. In general, a developmental disability occurs during the developmental period of a person's life. However, as a Consortium we are concerned with programs and policies that effect individuals with disabilities that occur at any point in their lives.

The over-sixty population of persons with developmental disabilities is expected to double within the next forty years due to: (a) people living longer (including those with disabilities); and, (b) the fact that higher numbers of persons with developmental disabilities enter the over-sixty group each year. We believe that many of these individuals should qualify for services offered under the Older Americans Act, and encourage you to consider the attached proposed amendments which could facilitate the process.

Finally, CCDD suggests that the authorization for Titles III and IV of the Act be increased by a minimum of five percent in order to better meet the needs of the growing population of older individuals with developmental disabilities.

Representatives of the Aging Task Force would welcome the opportunity to meet with you to discuss these recommendations. Please contact Ruth Katz (683-4202), Curt Decker (546-8202) or Matt Janicki (518/474-4904) if we can be of further assistance.

Sincerely,

Ruth E. Katz
Ruth E. Katz

Curtis Decker
Curtis Decker

Matthew Janicki
Matthew Janicki

On behalf of:

American Association of University Affiliated Programs
American Speech-Language-Hearing Association
American Foundation for the Blind
Association for Retarded Citizens - U.S.
National Association of Protection and Advocacy Systems
National Association of Rehabilitation Facilities
National Association of State Mental Retardation Program Directors
National Easter Seal Society
National Head Injury Foundation
National Mental Health Association
The Association for Persons with Severe Handicaps

Enclosure: CCDD Proposed Amendments for 1987 Reauthorization of the Older Americans Act.

Consortium for Citizens with Developmental Disabilities Proposed Amendments for 1987 Reauthorization of the Older Americans Act

The following amendments are proposed to the Older Americans Act to meet three objectives: (a) to include mental health services and the needs of older individuals with mental and physical disorders in all relevant Sections, (b) to address the special needs of older persons with disabilities and severely impairing conditions, and (c) to encourage cooperative planning and service delivery between State and area agencies with other State and local agencies that provide services to the aged.

1. That Section 202, Functions of the Commissioner, be amended to include mental health services and address the needs of older persons with mental and physical disorders. The amendments would read as follows:

   a. Amend Section 202(a)(5) by inserting after "health services" the following: "(including mental health services);".

   b. Amend Section 202(a)(5) by adding the following new subsection:

   (A) Consult with national organizations representing the interests of older persons with severely impairing conditions, including but not limited to developmental disabilities, stroke, head injury, physical and sensory impairments, and mental disorders (including Alzheimer's disease and related disorders), to develop and disseminate information on population characteristics and needs, training of personnel, and to provide technical assistance designed to assist State and area agencies to provide services in collaboration with other state agencies to older persons with disabilities and severely impairing conditions."

   c. Amend Section 202(b)(1) by deleting "and" after "(42 U.S.C. 3001-4)" and by inserting after "Social Security Act," the following: "with the Alcohol, Drug Abuse and Mental Health Administration, State rehabilitation agencies, and the State developmental disabilities planning councils designated under Section 124(a)(1) of the Developmental Disabilities Act;"

2. That Section 203(b)(14), Federal Agency Consultation, be amended to include the Alcohol, Drug Abuse and Mental Health Services Block Grant. The amendment would read as follows:

   Amend Section 203(b) by striking the "and' at the end of paragraph 13, and adding the following new paragraph: "(14) the Alcohol, Drug Abuse and Mental Health Services Block Grant Act, and". Renumber the following paragraph previously designated "(14)" as "(15)".

3. That Section 206(c), Evaluation, be amended to include organizations representing individuals with mentally and physically impairing conditions. The amendment would read as follows:

   Amend Section 206(c) by inserting after "including those representing" the following: "individuals with mentally and physically impairing conditions and those representing".

4. That Section 302, Definitions, be amended to include mental health services. The amendment would read as follows:

   Amend Section 302(11) by inserting after "provision of health" the following: "(including mental health)".

5. That Section 305(a)(2), Organization, be amended to include contact between the State Agencies and the State Departments of Mental Health and between Area Agencies on Aging and local Departments of Mental Health, and include contact between State and Area Agencies with other State agencies whose primary responsibility are for individuals with mental retardation, developmental disabilities, or other life-long handicapping conditions. The amendment would read as follows:

   Amend Section 305(a)(2)(D) by striking "and" at the end of the paragraph; Section 305(a)(2)(E) by inserting "and" at the end of the paragraph; and adding the following new paragraphs:

   "(F) encourage the development of cooperative arrangements between State agencies and State departments of mental health and between area agencies on aging and local departments of mental health to provide programs and services for the elderly residing in the community who are in need of mental health care; and

   (G) encourage the development of cooperative arrangements with State and area agencies with primary responsibility for individuals with mental retardation, developmental disabilities, or other handicapping conditions, and encourage collaborative programs to meet the needs of vulnerable older individuals with these conditions."

6. That Section 306, Area Plans, be amended to include the elderly who are mentally and physically impaired. The amendments would read as follows:

a. Amend Section 306(a)(5)(B) by inserting after "rural elderly" the following: "elderly with mentally and physically impairing conditions, including but not limited to developmental disabilities, stroke, head injury, physical and sensory impairment, and mental disorders,".

7. That Section 307, State Plans, be amended to include mental health services and to assure cooperative planning to provide for in-service training and collaboration on the provision of services for individuals with mental retardation, developmental disabilities, or other handicapping conditions. The amendments would read as follows:

a. Amend Section 307(a)(3)(A) by inserting after "legal assistance" the following: "and mental health services."

b. Amend Section 307(a)(17) by adding the following new subsection: "Provide that with respect to mental health assistance:

(A) the plan encourage area agencies on aging (i) to enter into interagency or other formal agreements with public or private nonprofit entities providing mental health services to ensure a coordinated approach in the delivery of mental health and psychosocial services to the elderly; and (ii) in the development of public education programs, to identify and refer for service older adults in need of mental health services.

c. Amend Section 307(a)(18) by adding the following new subsection: "Provide that with respect to older persons with mental retardation or other developmental disabilities (as defined in Section 102(7) of the Developmental Disabilities Act of 1984):

(A) the plan encourages each State to (i) cooperatively plan and provide training and collaboratively provide for services for older persons with disabilities; (ii) coordinate service planning with the state developmental disabilities planning council designated under Section 124(a)(1) of the Developmental Disabilities Act; and (iii) coordinate the planning, enumeration, assessment of needs, and service provision for older persons with developmental disabilities with the state mental retardation/developmental disabilities agency.

Renumber the following paragraphs previously designated "(17)" as "(19)", "(18)" as "(20)", '(19)" as '(21)", "(20)" as "(22)", and "(21)" as "(23)".

8. That Section 321(b), Part B -- Supportive Services and Senior Centers, be amended to include reference to mental health services and encourage interagency agreements to improve mental health services for the elderly. The amendment would read as follows:

   a. Amend Section 321(a)(1) by inserting after "health" the following: "(including mental health)".

   b. Amend Section 321 by redesignating subsection "(b)" as "(c)" and inserting immediately antecedent the following new subsection: "(b) the Commissioner shall encourage Area Agencies on Aging to enter into interagency or other formal agreements with public or private nonprofit entities providing mental health services to ensure a coordinated approach in meeting the mental health and psychosocial needs of the elderly."

9. Insert a separate section within Title III for the nursing home ombudsman program which would specify the purpose, authority function and authorization for the program. This separate section should assure that the ombudsman program: (a) is conflict free in order to most effectively monitor conditions in nursing homes including independence from service providers and (b) has the ability to pursue legal, administrative and other appropriate remedies. This section should also require cooperation with the protection and advocacy system for the developmentally disabled and mentally ill and provide demonstration monies to enhance that relationship.

10. That Section 401, Statement of Purpose, be amended to include a reference to older persons with special needs. The amendment would read as follows:

    Amend Section 401(3) by adding the following new paragraph: "(3) collaborative projects joining aging with professions specializing in providing treatment and services to those with disabilities and mental disorders (including Alzheimer's disease and related disorders)."

    Renumber the following paragraphs previously designated "(3)" as "(4)", and "(4)" as "(5)".

11. That Section 411(a)(1), Grants and Contracts, be amended to include mental health care and include the use of the more accurate terminology "Alzheimer's disease and related disorders."

    a. Amend Section 411(a)(1) by inserting after "health care," the following: "(including mental health care)".

b. Amend Section 411(c) by deleting "Alzheimer's disease and other neurological and organic brain disorders of the Alzheimer's type" and inserting the following: "Alzheimer's disease and related disorders with neurological and organic brain dysfunction".

12. That Section 412(a), Multidisciplinary Centers of Gerontology, be amended to include mental health services as an emphasis. The amendment would read as follows:

    Amend Section 412(a) by inserting the following after "health": "(including mental health)".

13. That Section 413 be created to enable the Commissioner to enter into cooperative agreements with the Commissioner of the Administration on Developmental Disabilities in order to establish education and training programs in aging and developmental disabilities, and to authorize joint grants to public and private nonprofit agencies, organizations, and institutions for the support of multidisciplinary centers that would train personnel to work with older individuals with mental retardation and developmental disabilities. The amendment would read as follows:

    Amend Title IV, Part A by adding the following new section: "Multidisciplinary Centers for the Mentally Retarded and Developmentally Disabled
    Section 413. The Commissioner in conjunction and agreement with the Commissioner of the Administration on Developmental Disabilities may make grants to private and public nonprofit agencies, organizations, and institutions of higher education for the purpose of establishing multidisciplinary centers in aging and developmental disabilities. Such centers shall conduct research and policy analysis, provide for the training of personnel, serve as a technical resource at the State level for State agencies, State developmental disabilities planning councils, State mental retardation/developmental disabilities agencies and service providers and at the national level, to the Commissioners and the Congress, and provide for other functions deemed necessary by the Commissioner. Such centers on aging and developmental disabilities shall --

    (1) develop and provide education programs for the training of personnel working with older developmentally disabled individuals;

    (2) conduct research on service practices;

    (3) provide technical assistance to State and area agencies providing for older individuals with developmental disabilities; and

(4) serve as repositories of technical information."

14. That Section 414 be created to improve mental health training for aging services providers. The amendment would read as follows:

    Amend Title IV, Part A by adding the following new section: "Special Population Training Section 414. The Commissioner may make grants to any public or private nonprofit entity and may enter into contracts with any public or private nonprofit entity to develop and provide training programs to Title III service providers and nursing home care providers to meet the special service needs of elderly with: (a) mental, emotional or behavioral disorders; or (b) physical, and sensory disabilities, who are residing either in the community or in nursing care facilities."

15. That Section 422, Demonstration Projects, be amended to include the location of older severely mentally ill persons who are increasingly living into old age. The amendment would read as follows:

    Amend Section 422(b)(2)(A) by inserting after "mental health services" the following: "or who are severely mentally impaired".

16. That Section 422(b)(2) be amended by adding the following subsections:

    (E) the identification and provision of services to elderly individuals (including individuals who experience lifelong or extended disabilities) with disorders of speech, language and/or hearing that interfere with their ability to function socially or independently; and

    (F)the provision of rehabilitation services, and communication aids and devices to assist individuals (including individuals who experience lifelong or extended disabilities) with severe speech, language and hearing disorders.

17. That Section 423, Special Projects in Comprehensive Long-Term Care, be amended to include allowing grants for the development of programs to address the needs of the estimated 50% or more of nursing home residents who have severe mental impairment. The amendment would read as follows:

    Amend Section 423(a)(3) by inserting after "geriatric health maintenance organizations" the following: "services to the severely mentally impaired residing in nursing homes;".

THE UNIVERSITY OF MARYLAND
CENTER ON AGING

The National Center on Aging and Disabilities

6 April 1987

Senator Spark Matsunaga
Attn: Lois Fu
Subcommittee on Aging
Room 109, Hart Senate Building
Washington, DC 20510

Dear Senator Matsunaga:

I would like the following information to become part of the hearing record for March 31, 1987 on the changing needs of the elderly related to the reauthorization of the Older Americans Act. I have purposefully made my written testimony short, and have included a number of attachments which I hope will interest your staff, and which you may want to include for the record.

My name is Dr. Thomas Rose. I am a Research Associate at The National Center on Aging and Disabilities, Center on Aging, University of Maryland, College Park, Maryland 20742. For the past two years we have concentrated our efforts on understanding and planning for the needs of elderly persons with developmental disabilities and mental retardation.

With my associates we have written a number of articles about Older Developmentally Disabled Adults. We have been especially concerned with the plight of this underserved vulnerable minority. You will find useful statistics and other information in the attached article, and in an article that I have written for the Spring 1987 issue of Aging published by the Administration on Aging. In addition, with my associates, we have presented papers about older developmentally disabled citizens at a number of national and state conferences including: The Gerontological Society of America, The Orthopsychiatric Society, The Association for Gerontology in Higher Education, The Young Adult Institute, etc.

With funding from the Maryland State Planning Council on Developmental Disabilities, we have just completed an 18 month research and planning study about aging and developmental disabilities in Maryland. We have placed emphasis on the policy and programmatic implications as developmentally disabled citizens grow older. Our final report will be available in late April, 1987.

As part of the Maryland study, The National Center on Aging and Disabilities at the Center on Aging has established a National Aging and Developmental Disabilities Information Exchange which offers information on demonstration and model projects, bibliographies, and other materials. I have attached some of these materials with this testimony.

With the support of a number of foundations and organizations we have organized a national conference on Aging and Life long Disabilities: Partnership for the Twenty First Century in June, 1987 at the Wingspread Conference Center in Racine, Wisconsin. The participants will include state directors of aging and state directors of developmental disabilities/mental retardation, and representatives of a number of national aging and disability organizations. The cosponsors of this conference include, among others: The National Association of State Units on Aging, The National Association of State Mental Retardation Program Directors, The Joseph P. Kennedy Foundation, and the National Institute on Aging. The final report of this conference will be practical and policy oriented, and distributed to more than 3000 organizations and individuals in the fields of aging and developmental disabilities. I have attached an agenda and summary about the conference.

Finally, the Center on Aging has focused on education and training as more aging developmentally disabled persons are served by the aging and developmental disabilities networks. We have developed a state-wide conference, curriculum materials, two day work shops, bibliographies and resource materials, and have submitted a major training proposal to the Department of Health and Human Services.

If there is any way we can assist your committee, please call on us at anytime. Thank you for making this testimony part of the record.

Sincerely,

Thomas Rose, Ph.D.
Research Associate

[NOTE: In the interest of economy, the attachments accompanying Mr. Rose's statement were retained in the files of the Committee.]

NATIONAL ASSOCIATION OF
AREA AGENCIES ON AGING
"Reaching the Nation's Elderly"

MINORITY PARTICIPATION IN THE AGING NETWORK:

A SELECTED VIEW FROM THE NATIONAL DATA BASE ON AGING

by

Mark S. Rosentraub
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INTRODUCTION

The National Data Base on Aging, maintained by the National Association of Area Agencies on Aging and the National Association of State Units on Aging, provides an opportunity to understand the extent to which minorities participate in the management of the aging network and receive services from this system. This brief report is organized into three sections to provide an overview of minority participation. The first section assesses minority involvement in the management of the aging network of state units and area agencies. Part II of the report focuses on service delivery by assessing the proportion of contractors who were members of minority groups and the proportion of service recipients who were members of minority groups. Part III provides some concluding observations.

When minority participation is discussed, the main issue is the level of participation. Simply put, this issue is concerned with the possibility that minorities receive fewer positions or services relative to the their distribution in the population. For this report, U. S. Census figures on the proportion of elderly population that is minority were used where comparisons were required. The U. S. Bureau of the Census has estimated that 14.1 percent of all Americans over the age of 60 are members of a minority group.

Part I

MINORITY PARTICIPATION IN ADMINISTRATION OF THE AGING NETWORK MAINTAINED BY AREA AGENCIES AND STATE UNITS

State Units On Aging

Less than one-fifth of all state unit directors were members of minority groups in 1984. However, the 18 percent of state unit directors who were members of minority groups represented a 7 percent increase from 1982 (see Figure 1). From 1981 through 1984, the proportion of state unit staff which were classified as minority group members remained at about the same levels. In 1981, 19.1 percent of all staff members were minorities; this declined to 17.5 percent in 1984 with the largest drop taking place between 1981 and 1982 (see Figure 2). The last management group analyzed was the advisory councils which serve state units. Data for this group was available only for 1984; in that year, 22 percent of all advisory council members were from a minority group (see Figure 3).

Area Agencies On Aging

At the area agency level, there were fewer directors from minority groups. In 1982, 8.5 percent of the directors were classified as minorities. This increased to 11.6 percent in 1984

Figure 1
MINORITY PARTICIPATION:
STATE UNIT DIRECTORS, 1982-1984

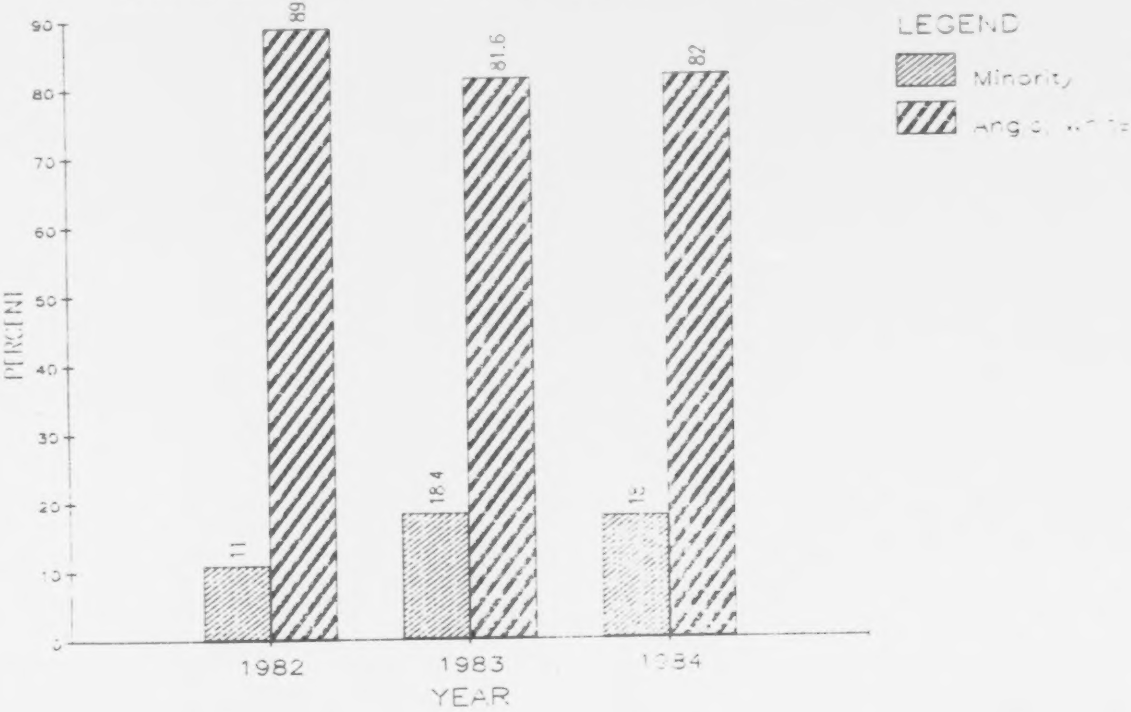


Figure 2
MINORITY PARTICIPATION:
STATE UNIT STAFF, 1981-1984

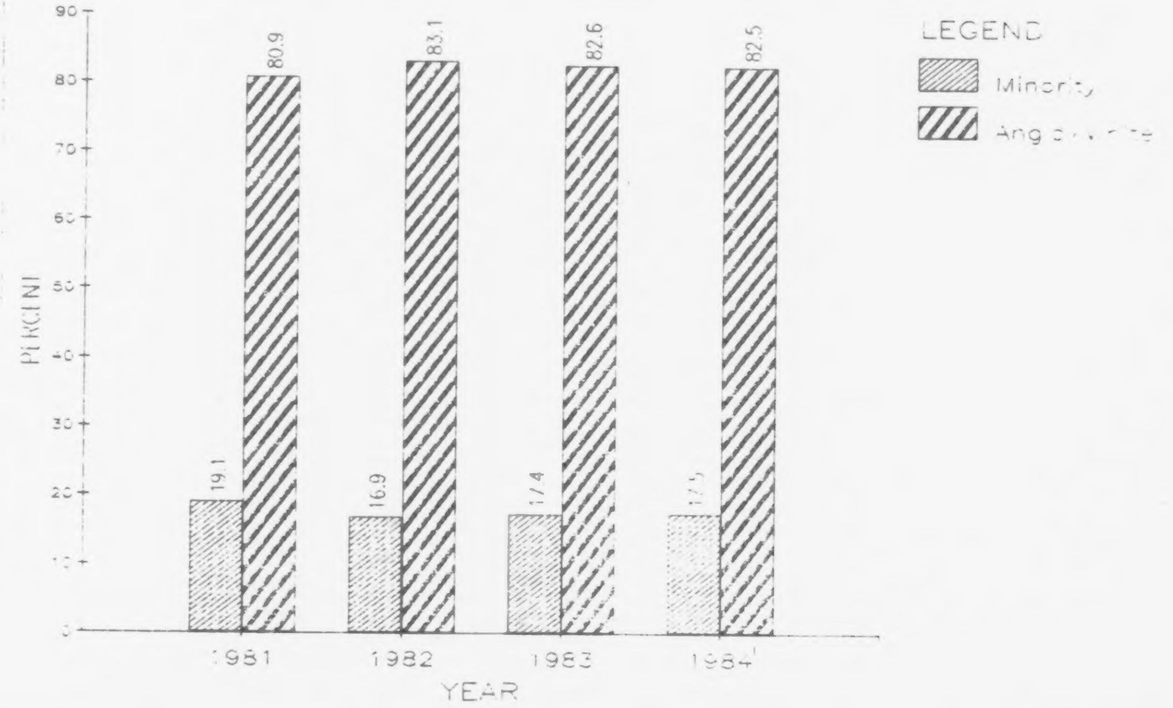


Figure 3
MINORITY PARTICIPATION:
STATE UNIT ADVISORY COUNCILS,
1984

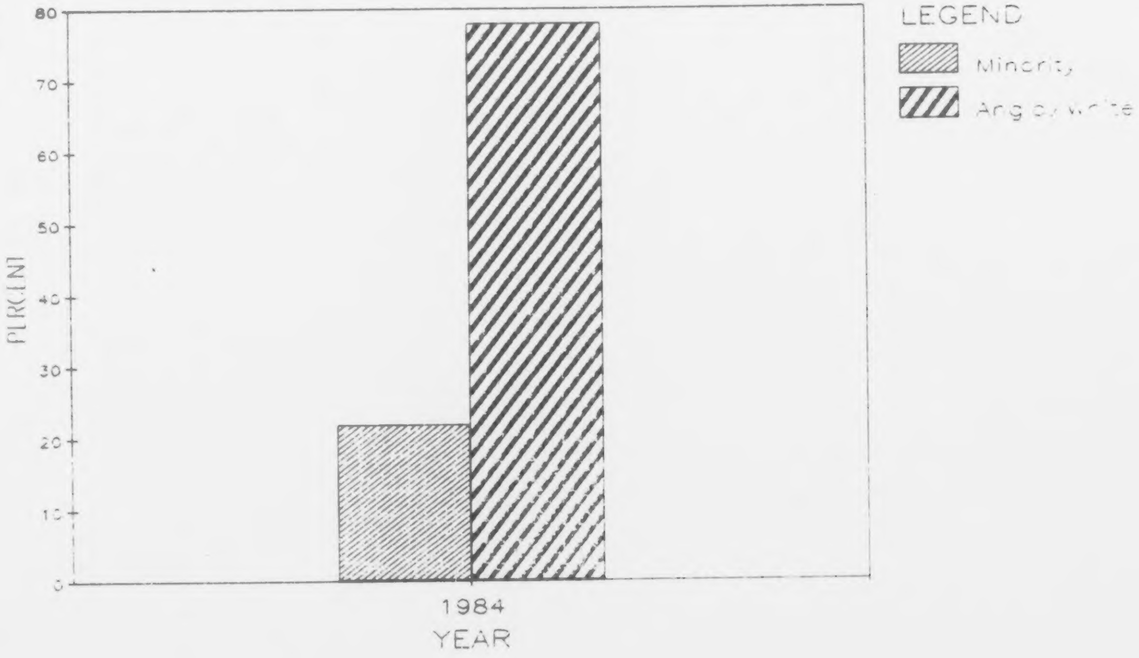


Figure 4
MINORITY PARTICIPATION:
AREA AGENCY DIRECTORS, 1982-1984

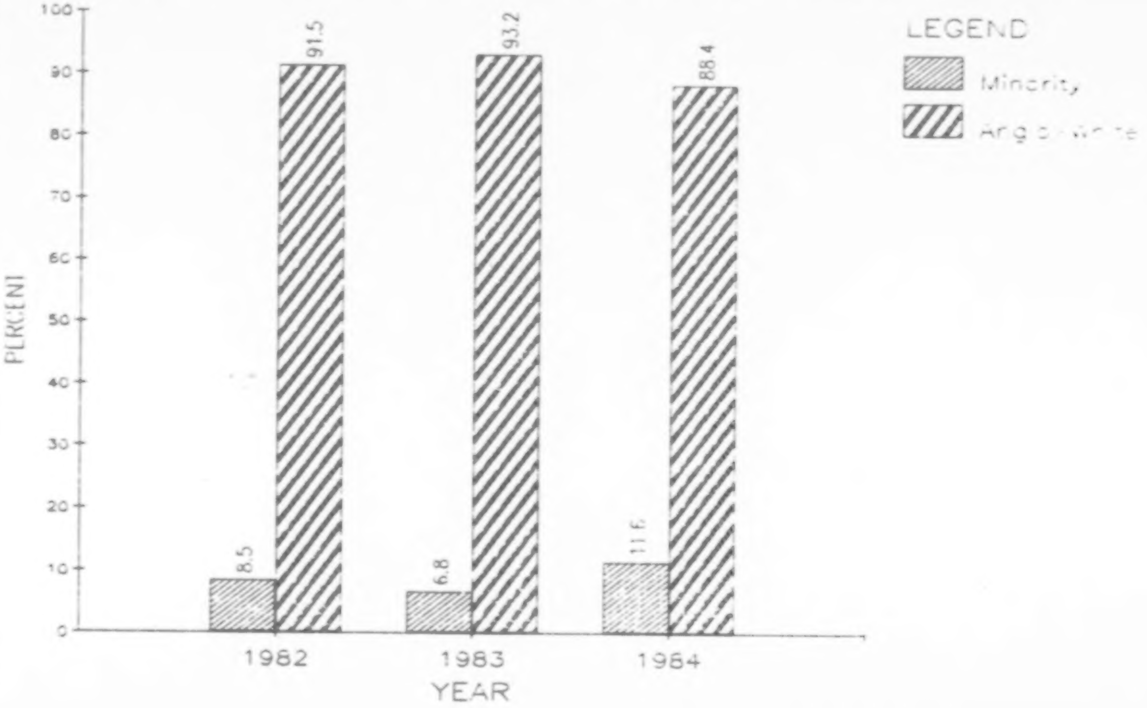


Figure 5
MINORITY PARTICIPATION:
AREA AGENCY STAFF, 1981-1984

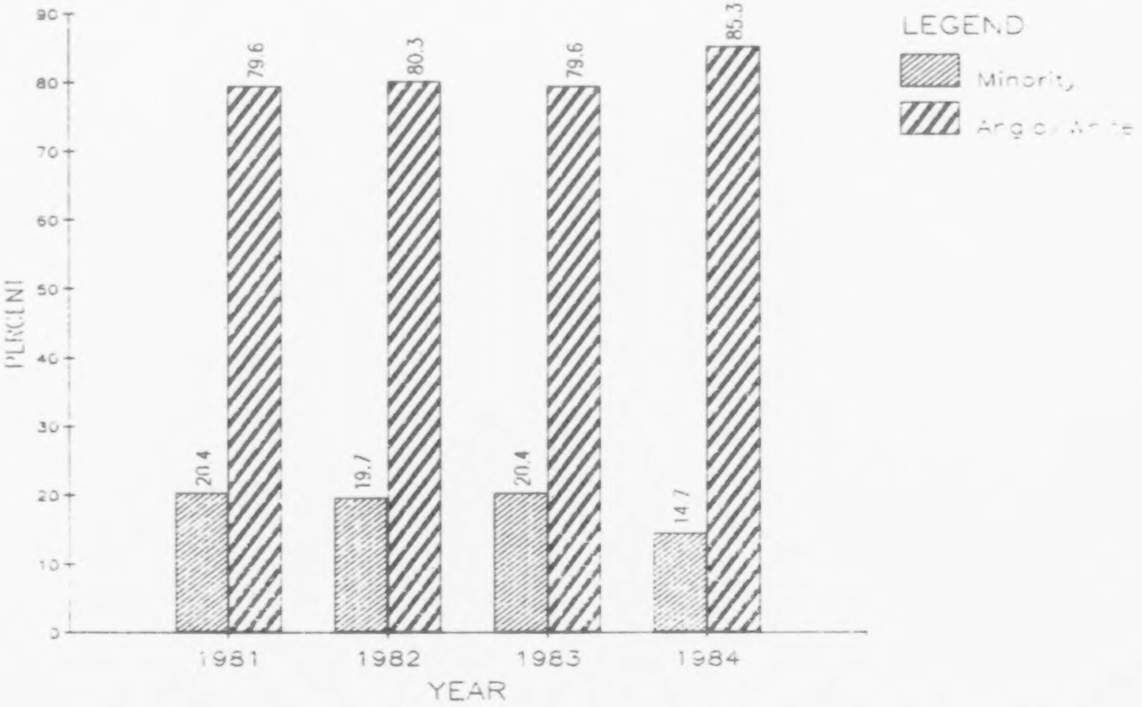


Figure 6
MINORITY PARTICIPATION:
AREA AGENCY ADVISORY COUNCILS,
1984

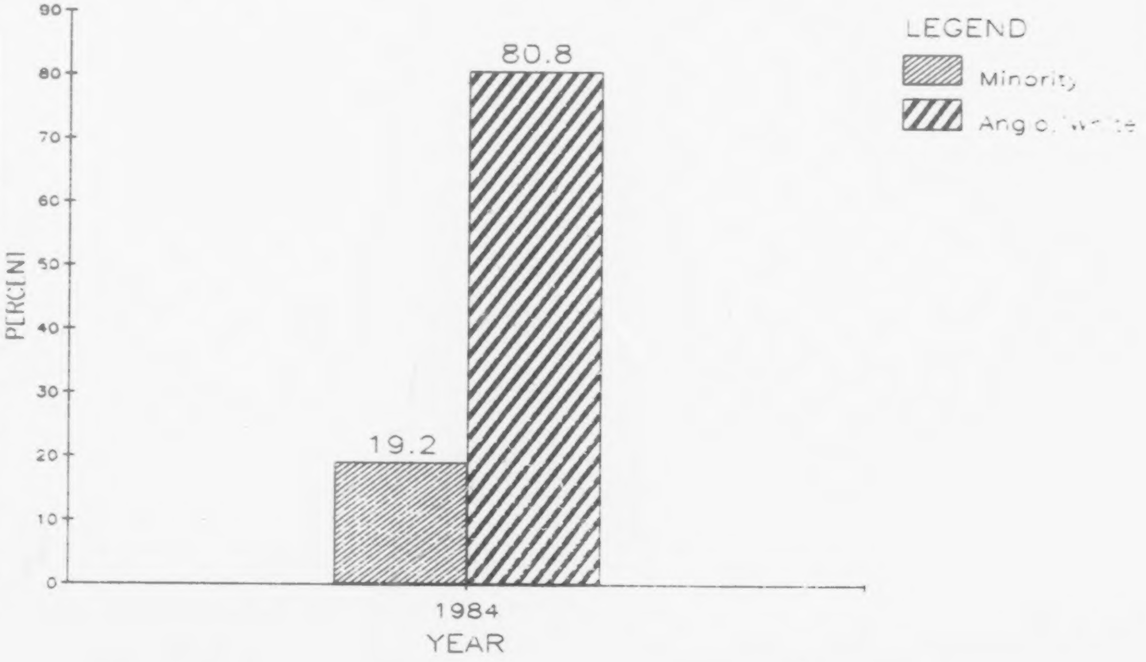


Figure 7
MINORITY PARTICIPATION:
CONTRACTS AWARDED TO SERVICE
PROVIDERS, BY RACE, 1983-1984

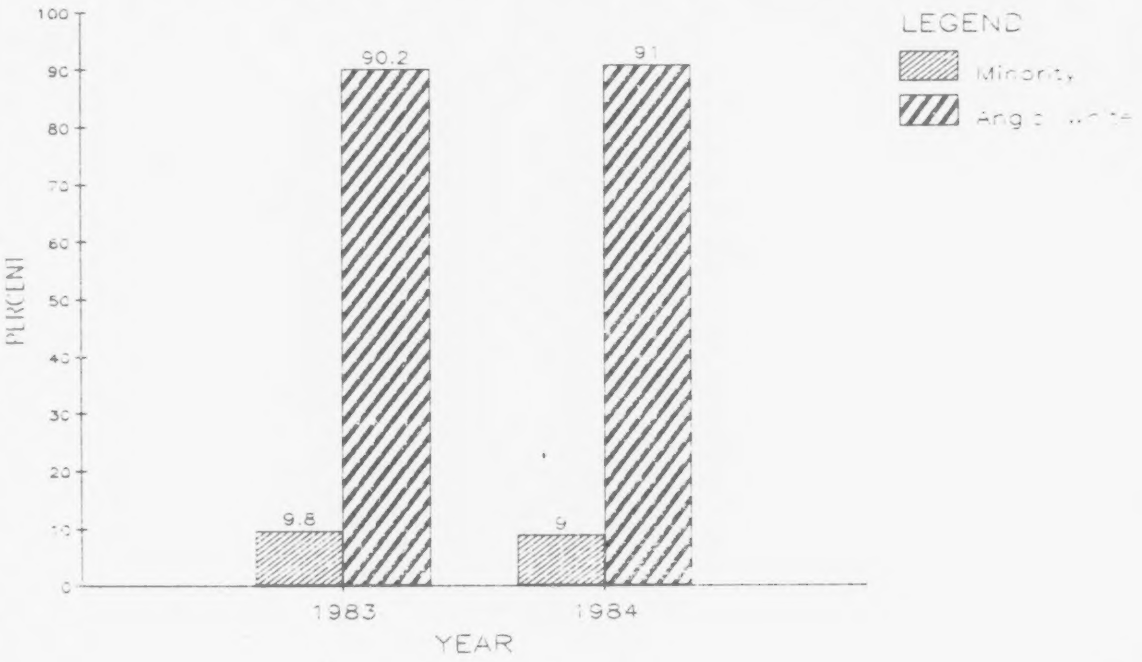
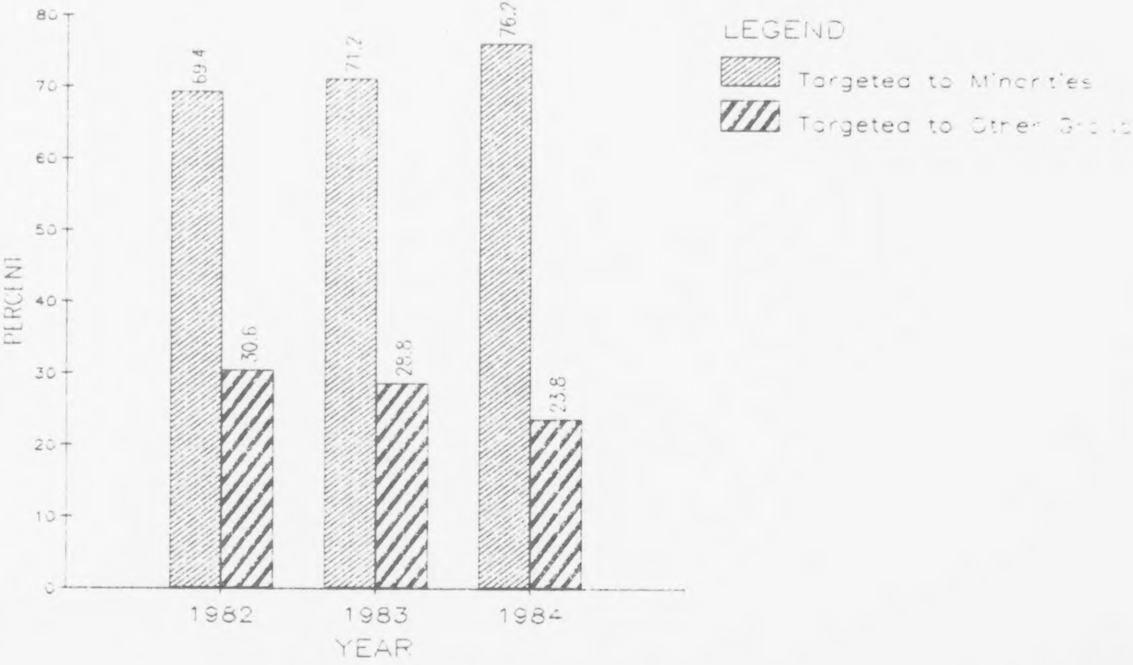


Figure 8
MINORITY PARTICIPATION:
CONTRACTS TARGETING SERVICES TO
MINORITIES, 1982-1984



(see Figure 4). The proportion of area agency staff who were from minority groups decreased from 1981 to 1984. After remaining basically constant from 1981 to 1983 at the 20 percent level, minority staff represented 14.7 percent of all staff members in 1984 (see Figure 5). At the advisory council level, 19.2 percent of all members working with area agencies were classified as minority group members in 1984 (see Figure 6).

Part II

MINORITY PARTICIPATION IN THE SERVICE SYSTEM

Contractors and Contracts

Minority vendors have received approxiately 9 percent of all contracts awarded for service delivery in 1983 and 1984 (see Figure 7). When contracts required that services be targeted to specific groups, minorities were usually the beneficiaries of this requirement. In 1982, 69.4 percent of all targeted contracts focused on minorities. This increased to 76.2 percent in 1984 (see Figure 8).

Service Recipients

Three separate tables were created to review the proportion of minority group members receiving services from the area agency network. These tables cover selected servies in 1982, 1983, and 1984. The services selected were those considered most important for all elders. In each year and for each service, a differential was calculated by subtracting the proportion of elders which were minority 14.1 percent (determined by the U. S. Bureau of the Census) from the percentage of service recipients who were members of minority groups. A positive figure meant MORE minority group members received services than would have been expected based on their proportion of the population. A negative number meant fewer minroities received services.

In 1982, more minorities were served than would have been expected for each of the 11 services studied. The differential was greatest for escort services, 21.5 percent, and lowest for counseling services, 1.1% (see Table 1). In 1983, one negative differential emerges, counseling; for the other 10 services, however, the differentials were positive. It is important to note, however, that the differentials were not as large in 1983 and they were in 1982 (see Table 2). In 1984, there were three negative differentials as agencies seemed to be having larger problems serving minority populations (see Table 3).

Part III

CONCLUDING OBSERVATIONS

Aggregate numbers sometimes tell part of a story. From the aggregate numbers presented here, there are clearly areas where more minority participation is necessary. Yet, there is evidence which suggests minorities are well represented in the aging network maintained by state units and area agencies on aging.

These conclusions, of course, are based on the U. S. Bureau of the Census' estimate that minorities represent 14.1 percent of all people 60 years of age and older. If this proportion of minority representation was the goal for service bureaucracies, service providers, and service recipients, than the aging system is performing quite well. More emphasis on recruiting minorities for area agency directors is needed as is a greater emphasis on using minority service providers. Care must also be taken at the area agency level to insure that there is no further decline in the proportion of staff members who are members of minority groups.

At the service delivery level, while these data do not consider the effect of income on service need and do not measure service quality, the proportion of service recipients who were members of minority groups was usually greater than 14.1 percent. This declined from 1982 to 1984 and may be associated with the need for funds to identify minority elders. However, staff should be concerned about this decline to insure that it does not get worse.

Table 1

RACIAL CHARACTERISTICS OF SERVICE RECIPIENTS AND PROJECTED DIFFERENTIALS FROM POPULATION ESTIMATES: 1982

Service	Percent Minority	Differential[1]
Advocacy	19.5	+5.4
Assessment	23.3	+9.2
Chore	20.2	+6.1
Counseling	15.2	+1.1
Escort	35.6	+21.5
Housekeeping	21.1	+7.0
Meals -- Congregate	20.1	+6.0
Meals -- Delivered	22.9	+8.8
Personal Care	25.0	+10.9
Transportation	27.6	+13.5
Visiting	28.7	+14.6

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[1] Differential calculated by subtracting from the percentage of service recipients who were classified as minority the percentage of all elders who were classified by the U. S. Bureau of the Census as minority. This figure is 14.1 percent. A positive number would mean more minority individuals received services than would be expected given their absolute distribution in the population. A negative number would mean fewer minority individuals received services than would have been expected.

SOURCE: National Data Base On Aging

Table 2

RACIAL CHARACTERISTICS OF SERVICE RECIPIENTS AND PROJECTED DIFFERENTIALS FROM POPULATION ESTIMATES: 1983

Service	Percent Minority	Differential[1]
Advocacy	15.6	+1.5
Assessment	15.0	+ .9
Chore	17.4	+3.3
Counseling	10.7	-3.4
Escort	21.4	+7.3
Housekeeping	17.9	+3.8
Meals -- Congregate	15.4	+1.3
Meals -- Delivered	20.8	+6.7
Personal Care	16.2	+2.1
Transportation	21.6	+7.5
Visiting	27.4	+13.3

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[1] Differential calculated by subtracting from the percentage of service recipients who were classified as minority the percentage of all elders who were classified by the U. S. Bureau of the Census as minority. This figure is 14.1 percent. A positive number would mean more minority individuals received services than would be expected given their absolute distribution in the population. A nagative number would mean fewer minority individuals received services than would have been expected.

SOURCE: National Data Base On Aging

Table 3

RACIAL CHARACTERISTICS OF SERVICE RECIPIENTS AND PROJECTED DIFFERENTIALS FROM POPULATION ESTIMATES: 1984

Service	Percent Minority	Differential[1]
Advocacy	6.0	-8.1
Assessment	12.9	-1.2
Chore	27.0	+13.1
Counseling	17.0	+3.1
Escort	36.6	+22.5
Housekeeping	17.4	+3.2
Meals -- Congregate	14.4	+ .3
Meals -- Delivered	16.4	+2.3
Outreach	21.2	+7.1
Personal Care	10.0	-4.1
Transportation	16.2	+2.1
Visiting	23.3	+9.2

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[1] Differential calculated by subtracting from the percentage of service recipients who were classified as minority the percentage of all elders who were classified by the U. S. Bureau of the Census as minority. This figure is 14.1 percent. A positive number would mean more minority individuals received services than would be expected given their absolute distribution in the population. A nagative number would mean fewer minority individuals received services than would have been expected.

SOURCE: National Data Base On Aging

STATEMENT OF
BESSIE B. MOORE
VICE CHAIRMAN
NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE
BEFORE THE
UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON AGING

My name is Bessie B. Moore. I am Vice-Chairman of the U.S. National Commission on Libraries and Information Science (NCLIS) and have been elected annually to this position by the Members of the Commission since 1971.

Thank you, Mr. Chairman for this opportunity to submit written testimony on behalf of NCLIS in support of reauthorization of the Older Americans Act. At the 1971 White House Conference on Aging, the delegates looked at all of the federal legislation affecting the aging and recommended changes. They wanted to insure that all policy making bodies at the national level had at least one member whose job it was to look after the needs of the aging. Congress responded, and one of the laws amended as a result of that White House Conference was the law for the National Commission on Libraries and Information Science which now requires that at least one person shall be knowledgeable with respect to the library and information service and science needs of the elderly. I am that person.

Through the years, I have participated in White House Conferences on Aging and the Commissioner on Aging's Forums and have learned much about developments in the growing field of aging. I am also a member of the Governor's Commission on Aging in Arkansas. I receive personal value from these experiences as I am 84 years of age, but my interests extend much farther in that I always attempt to translate the information and knowledge gleaned into ways libraries and information services can provide better service to the elderly. As a result of these meetings, I contacted and explored with the Administration on Aging the development of a Memorandum of Understanding that would commit both our agencies to work cooperatively at the federal level and through our respective networks to promote improvement and better use of library and information services for the older adult.

The Memorandum of Understanding was signed in March 1985 by Carol Fraser Fisk, Commissioner on Aging and Elinor Hashim, Chairman of the U.S. National Commission on Libraries and Information Science. We have found the Administration on Aging very cooperative and eager to help. NCLIS looks forward to this continued joint effort promoting better library and information services to the Nation's elderly.

We are indebted to the Congress for clarifying the intent of Congress with respect to cooperative efforts under the Older Americans Act during the last reauthorization. This action enabled cooperation between libraries and aging agencies at the state and local levels. A colloquy between Senators Grassley, Melcher and Pryor in the Senate and a soliloquy by Representative Pat Williams in the House made clear that local libraries could perform services authorized under the Older Americans Act. This interchange aided further cooperation and has produced inspiring results beginning with the NCLIS/AoA Memorandum of Understanding. The U.S. National Commission on Libraries and Information Science now also has a Memorandum of Understanding with ACTION.

This June at the annual conference of the American Library Association, NCLIS, the American Library Trustees Association and other divisions of the American Library Association will present a landmark program on "Developing Partnerships in Providing Library and Information Services to the Elderly." We have involved state and local aging agency personnel as well as library professionals in the development of the program. This will be the first time professionals from the fields of aging and librarianship will work together in the development of a national program. We are very excited about the anticipated results, as participants will return to their locales all over the nation and institute the ideas they gained from this program. We believe that cooperation and collaboration are the keys to quality service and this program will show the way.

The Older Americans Act is an effective piece of legislation that contributes to cooperation and is a vehicle to improve and promote better use of library and information services to older adults and those providing services to them.

I speak for the U.S. National Commission on Libraries and Information Science which strongly supports reauthorization of the Older Americans Act. We believe in the importance of the Act in delivering much-needed services to older Americans.

MEMORANDUM OF UNDERSTANDING

BETWEEN THE
ADMINISTRATION ON AGING (AoA)
OFFICE OF HUMAN DEVELOPMENT SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

and the

NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE (NCLIS)

PURPOSE AND SCOPE

The purpose of this Memorandum of Understanding (MOU) between the Administration on Aging and the National Commission on Libraries and Information Science is to establish a commitment to work cooperatively at the Federal level and through their respective networks in order to promote the improvement and better use of library and information services to the aging.

The steady increase in the population of persons 65 years and older requires that adequate library and information services be available to meet the special needs of this segment of the population now and in the future.

There is a need for improved library and information services and programs for the elderly in this Nation in order that the wide variety of information needs of our aging population can be met. However, reports from the field indicate a reduction in services and programs resulting from a variety of factors. Most can be attributed to a lack of understanding on the part of policymakers and decision-makers of the role of public libraries in serving the elderly.

Cooperation is the key to success. Professional librarians, who are knowledgeable in serving the aging, working in collaboration with professionals in the aging field and organizations serving the elderly, can promote improvement and better use of library and information services to the elderly.

Increased emphasis needs to be placed on improving library and information services to the aging. Resolution 371 from the 1981 White House Conference on Aging states:

> The National Commission on Libraries and
> Information Science is mandated to give attention
> to the needs of the elderly.
> [and] That it move quickly to give leadership to
> the information needs of the elderly...

The "move quickly" seems a not-too-gentle reminder for the Commission to pursue its mandate which in Sec. 5. (a) (2) of the Commission's enabling legislation states NCLIS is to

> Conduct studies, surveys, and analyses of the library and informational needs of rural areas, of economically, socially or culturally deprived persons, and of elderly persons.

The scope of this memorandum is limited to activities designed to encourage and promote the use of public libraries as community based and supported institutions in meeting the library and information needs of the elderly and those serving the elderly.

THE ROLE OF NCLIS

[illegible] a permanent, independent executive branch agency created by PL 91-345 to advise the President and Congress on national policies for America's library and information needs. In discharging its primary responsibility, NCLIS "conducts studies, surveys, and analyses of the library and informational needs of the Nation, including the special library and informational needs of...elderly persons...and the means by which these needs may be met,"... "appraises the adequacies and deficiencies of current library and information resources and services,..." and "develops overall plans for meeting national library and informational needs and for the coordination of activities at the Federal, State, and local levels... ."

In fulfilling its mandate, NCLIS is authorized additionally to advise State, local, and private agencies regarding library and information sciences as well as contract with Federal agencies and other public and private agencies to carry out its functions.

The heads of all Federal agencies are, to the extent not prohibited by law, directed to cooperate with the Commission in carrying out the purposes of the Commission.

THE ROLE OF AoA

AoA was created under the Older Americans Act of 1965, as amended, which established a Federal, State, and local partnership for the development of a comprehensive system of services for older persons to enable maximum independence in the later years. Title III of the Act authorizes the designation of State and Area Agencies on Aging in each State--the State agency being responsible for developing and coordinating aging programs throughout the State under a federally approved State plan and the Area Agencies on Aging being responsible for the provision of leadership and resources in the development of a comprehensive community-based service system. The Act states that area plans must "provide for the establishment and maintenenace of information and referral services in sufficient numbers to assure that all individuals within the planning and service area covered by the plan will have reasonably convenient access to such services."

In carrying out its responsibilities, AoA collaborates with other Federal, public, and private agencies by participating in joint initiatives which will have positive impact on aging populations.

OBJECTIVES OF MEMORANDUM OF UNDERSTANDING

Representatives of NCLIS and AoA have met to discuss how this MOU will serve to facilitate coordinated and cooperative efforts between the Administration on Aging and the National Commission on Libraries and Information Science in pursuit of the following objectives:

access to library and information services for the elderly to meet their special needs.

2. To increase the understanding of State and Area Agencies on Aging personnel regarding the opportunities offered by public libraries for meeting the informational, cultural, educational and recreational needs of the elderly.

3. To increase the understanding of State Library Agencies and local public libraries of the role that State and Area Agencies on Aging personnel perform in fostering the development of services for the elderly;

4. To collect information from the state and local level about exemplary library services for the aging in urban and rural areas in order to encourage program replication in other areas;

5. To encourage opportunities for development of program planning and coordinating linkages between State Library Agencies and State Agencies on Aging, and between local public libraries and Area Agencies on Aging.

ROLES AND RESPONSIBILITIES

AoA and NCLIS staff will meet for orientation about their respective programs.

The Adminstration on Aging, through its Office of Program Development, will undertake the following activities to implement this MOU:

1. AoA will encourage State Agencies on Aging to publicize through their field communications information about services offered to the elderly by State Library Agencies.

2. AoA will encourage the Network on Aging to distribute educational materials and resource information on aging to local libraries to enhance the libraries' community information and referral (CI&R) for the elderly and to inform persons about the services and programs which are within the Area Agency on Aging's planning and service area.

3. AoA will provide copies of the Coordinated Discretionary Funds Program announcement to NCLIS for distribution to the appropriate national, state, and local library and information organizations and agencies.

4. AoA will encourage area agencies on aging to assist local public libraries in the expansion of their outreach efforts to locate older persons who could benefit from library and information services.

5. AoA will disseminate information on exemplary library service to the aging through its Network on Aging.

The National Commission on Libraries and Information Science will undertake the following actions to implement this MOU:

1. NCLIS will encourage State Library Agencies to publicize through their field communications information about services offered to the elderly by State Agencies on Aging.

2. NCLIS will encourage local libraries, through the library and information network, to distribute material pertaining to library services and programs, including literacy programs, to Area Agencies on Aging, senior centers, nutrition sites and so forth.

3. NCLIS will disseminate information on exemplary library service to the aging through its library network.

4. NCLIS will encourage libraries to adopt newer information technologies in providing services to meet the special needs of the elderly.

5. NCLIS will work with appropriate library and information associations to encourage them to have local library staff become knowledgeable of the services provided by the Area Agencies on Aging in order to make the information about the local Area Agencies on Aging available to the public.

DURATION OF MOU

This MOU will remain in effect until amended by mutual consent.

MODIFICATION/CANCELLATION PROVISION

This MOU may be modified and/or terminated for cause upon mutual agreement.

AUTHORITY

This MOU is entered into under the authority of the Economy Act of June 30, 1932, Section 601 (31 U.S.C. 686b), and under the provisions of general and pertinent regulations of the Comptroller General.

ADMINISTRATION ON AGING

BY: Carol Fraser Fisk

Carol Fraser Fisk

Acting Commissioner on Aging

DATE: February 26, 1985

BY: Dorcas R. Hardy

Dorcas R. Hardy

Assistant Secretary for Human Development Services

DATE: MAR 4

NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE

BY:

Elinor M. Hashim

Chairman, NCLIS

DATE: February 1, 1985

Senator MATSUNAGA. The Subcommittee stands in recess subject to the call of the Chair.

[Whereupon, at 4:50 p.m., the Subcommittee was recessed, subject to the call of the Chair.]

OLDER AMERICANS ACT OF 1987

THURSDAY, APRIL 23, 1987

U.S. SENATE,
SUBCOMMITTEE ON AGING,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:30 p.m., in SD-430, Dirksen Senate Office Building, Senator Spark M. Matsunaga (chairman of the subcommittee) presiding.

Present: Senators Matsunaga and Cochran.

Also present: Senator Bingaman.

OPENING STATEMENT OF SENATOR MATSUNAGA

Senator MATSUNAGA. Good afternoon, ladies and gentlemen. This is the second in a series of three hearings on reauthorization of the Older Americans Act being held by this subcommittee. The first hearing, held on March 31, addressed the changing needs of the elderly. Now in this the second hearing, we will examine the extent to which the needs of the minority elders are being met through the Older Americans Act programs and what changes, if any, need to be made in the act to better address their needs.

We will also hear from the Commissioner on Aging, Carol Fraser Fisk, on the Administration's suggestions for changes in the act. Although the services and benefits under the act are intended to be available to all older persons, Congress has specifically required that Title III services be targeted to those older persons with the greatest economic or social needs, with particular attention to low income minority individuals.

Various organizations have brought to the attention of the subcommittee reports on declining participation of minorities in Title III programs over the last several years. We want to examine these reports and to determine what changes should be made in Title III to assure that minority older persons are receiving the services they need to the fullest extent possible.

It has been suggested that the current law be amended so that low income minorities will be served on the basis of need for services, that minority older persons be appointed to advisory boards of state and area agencies, and that other educational and enforcement measures be instituted to improve minority participation. We wish to examine all of these suggestions in order to determine how the legislation can be strengthened, and what steps the Administration on Aging should take to assure greater minority participation.

With respect to services to older Indians, we want to assess ways the program could be made more effective, especially in view of the vast unmet needs of this group. This includes, for example, reviewing how Title VI and Title III programs can be better coordinated, and what kinds of training and technical assistance efforts are needed to improve supportive and nutritional services to elderly Indians. Now, before I call upon the first witness, I have a request from Senator Hatch of Utah to insert his statement into the record immediately following mine.

[The prepared statements of Senators Matsunaga and Hatch follow:]

SENATOR SPARK M. MATSUNAGA
Chairman, Subcommittee on Aging
OPENING STATEMENT
MINORITY PARTICIPATION IN OLDER AMERICANS ACT PROGRAMS
430 Dirksen Senate Office Building
Washington, D.C.
Thursday, April 23, 1987 - 2:30 p.m.

Good afternoon, ladies and gentlemen.

This is the second in a series of three hearings on reauthorization of the Older Americans Act being held by the Subcommittee on Aging of the Committee on Labor and Human Resources. The first hearing, held on March 31, addressed the changing needs of the elderly. In this second hearing, we will examine the extent to which the needs of minority elders are being met through the Older Americans Act programs, and what changes, if any, need to be made in the Act to better address their needs. We will also hear from the Commissioner on Aging, Carol Fraser Fisk, on the Administration's suggestions for changes in the Act.

Although the services and benefits under the Act are intended to be available to all older persons, Congress has specifically required that Title III services be targeted to those older persons with the greatest economic or social needs, with particular attention to low-income minority individuals. Various organizations have brought to the attention of the Subcommittee reports on declining participation of minorities in Title III programs over the last several years. We want to examine these reports, and to determine what changes should be made in Title III to assure that minority older persons are receiving the services they need to the fullest extent possible.

Supportive and nutritional services are particularly important to this group in view of the higher rates of poverty experienced by minority elders, especially older minority women, as compared to the total elderly population. In 1985, the poverty rate for elderly blacks was almost three times greater than the rate for elderly whites; Hispanic elderly had a poverty rate almost double that of whites. While the poverty rate for the total elderly population was 12.6 percent in 1985, 34.8 percent of older black women and 27.4 percent of older Hispanic women had incomes below the poverty level. Problems associated with low income are exacerbated when older persons live alone, are in poor health, and are unable to carry out daily tasks without assistance. Such persons are among those who could particularly benefit from the services provided through State and area agencies.

It has been suggested that the current law be amended so that low-income minorities will be served on the basis of need for services, that minority older persons be appointed to advisory boards of State and area agencies, and that other educational and enforcement measures be instituted to improve minority participation. We wish to examine all of these suggestions in order to determine how the legislation can be strengthened, and what steps the Administration on Aging should take to assure greater minority participation.

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# # #

Statement of Senator Orrin Hatch, Utah
before the U.S. Senate
Hearing on Reauthorization of the Older Americans Act
Subcommittee on Aging

I would like to commend Senator Matsunaga and his Subcommittee on Aging for convening this series of hearings on the reauthorization of a very important piece of legislation, the Older Americans Act. This legislation will ensure the continuation of a program which has effectively provided essential social services for the elderly of our nation. Since it was passed originally in 1965, this Older Americans Act has provided money for programs that provide senior citizens with nutritious meals, for information and referral systems that help our seniors access centers that provide both companionship and services, and for programs that furnish transportation to help our aged senior citizens get from their homes to the services and opportunities mandated by the bill.

Recognizing the importance of this legislation to our seniors, I was an active participant in the past two reauthorizations of the Older Americans Act both as Chairman of the Labor and Human Resources Committee and as a conferee. During these deliberations, we made changes in the structure of the law to give state agencies on aging more flexibility in the management of the grants that pay for supportive services, senior citizens centers and nutrition programs. We found that many senior citizen centers were force to leave money unspent in one account while other accounts had resources remaining. Until the law was modified, in Utah many centers had to close their doors---turning away older people who needed nutritional hot meals--because no money remained to pay for the vehicle that brought the people to the centers to eat, although money remained to pay for the actual food. It is my hope that the flexiblity for states to fund particular geographical needs be expanded, or at least left intact.

Although the minority population in Utah is quite small, the American Indian Tribes in Utah are served by the Title VI funding. In surveying this population, I found that it would be more beneficial to leave this funding source as a separate categorial rather than to combine it with Title III funding. All of the Area Agencies on Aging within Utah already have a strong commitment to targeting specific population groups such as the ethnic minorities, low income minorities, those over 75, the mentally, emotionally, physically and developmentally handicapped, and those suffering from Alzheimer's Disease and other catastrophic illnesses. Since services are being provided to minorities within the frame-work of the current Older Americans Act, I do not feel that it is necessary to change local methods of targeting special groups.

I am also concerned about the proposal to raise the age eligibility from 60 to 70 years. This would decrease the emphasis on prevention and throw the system off balance. The majority of seniors in this age bracket do not want to be stigmatized as elderly unless their needs are great. The seniors receiving services often have one or more of the following problems: chronic health, isolation, physical limitations or emotional difficulties. If the age was raised to 70, it would decrease services to minorities who statistically have shorter life spans. By maintaining the eligiblilty at age 60, we are assisting in the prevention of elderly suicides, high health costs, enormous community costs, and excessive program costs.

I hope that my colleagues in the Senate and our counterparts in the House will support this legislation and assist in its rapid movement through both chambers. It is imperative to the well being our nation's greatest resource. We can not afford to postpone action on legislation which will meet the needs of our 38 million senior citizens. They deserve prompt action on this legislation.

Senator MATSUNAGA. Our first witness today is the U.S. Commissioner on Aging, Mrs. Carol Fraser Fisk. Mrs. Fisk has held this post since September 1986, and prior to her appointment had been the Acting Commissioner on Aging for two years. Mrs. Fisk is here today to present the Administration's proposal for the reauthorization of the Older Americans Act, and specifically to address the issue of services to minorities under this Act. Mrs. Fisk is accompanied by Mr. Cook, is it?

Mrs. FISK. Mr. Smith is accompanying me.

Senator MATSUNAGA. Mr. Smith. That's a most unusual name. [Laughter.]

Mrs. Fisk, I am delighted to have you join us. You may proceed.

STATEMENT OF CAROL FRASER FISK, U.S. COMMISSIONER ON AGING, WASHINGTON, DC, ACCOMPANIED BY DONALD SMITH, DIRECTOR, OFFICE OF MANAGEMENT AND POLICY, ADMINISTRATION ON AGING

Mrs. FISK. Thank you very much, Mr. Chairman. It is my pleasure to be with you today to have the opportunity to talk about the reauthorization of the Older Americans Act. As I said, I am accompanied by Mr. Donald Smith who is the Director of the Office of Management and Policy within the Administration on Aging.

I want to assure you of both my personal commitment and that of this administration to reauthorization of a strong, viable, and responsive Older Americans Act. I believe that the Older Americans Act passed by the Congress more than 21 years ago this past July is one of the most important and successful pieces of legislation for older persons ever passed.

In 1965, the appropriation level was only $7.5 million. In fiscal 1987, appropriations under the Act total $724.5 million. The Act provides grants to states to foster the development of comprehensive and coordinated service systems to serve older Americans in order to (1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services; (2) remove individual and social barriers to economic and personal independence for older individuals; and (3) provide a continuum of care for the vulnerable elderly.

As the Administration on Aging begins the third decade of administering the Older Americans Act, we are undertaking a critical examination of what has been accomplished and what remains to be done. We must operate within the framework of the changing demographics of the elderly and of the families of which they are a part while still ensuring that the Nation's neediest older persons continue to receive the assistance they require to remain self-sufficient and independent within their own community.

Two critical issues are emerging which necessitate an intensive examination and reassessment of the Administration on Aging's programmatic and discretionary authorities now and in the years ahead. One challenge, of course, is the rapid growth of the elderly population. Between 1980 and the year 2000, the population age 60 and over is expected to increase approximately 27 percent and to represent 17 percent of the United States population.

This proportion may climb to more than one in four persons by the year 2030, nearly 82 million older people. This graying of American society will have a significant impact on every major social institution, particularly social services, in the decades ahead.

A second major challenge will be to focus on increasingly scarce public resources on those older persons most in need of assistance. Frequently these persons, the most vulnerable, are women, minorities, low income persons and the very old.

The Administration on Aging is undertaking more aggressive efforts to assist vulnerable older persons and their families in finding appropriate help to maintain their independence within their own communities or to delay or prevent unnecessary institutionalization.

For this assistance to be effective, communities must take positive action to build integrated and responsive systems of care. AOA has taken the initiative to strengthen the role of State and Area Agencies on Aging as catalysts, information referral centers, and as brokers of service to help enhance, not replace, individual self-sufficiency, family care giving, and other traditional forms of community support.

The building and strengthening of coordinated community service systems for the elderly and their families is the top priority for the Administration on Aging. We want to assure that each and every community in this nation is a good place to live and to mature.

I believe that the Administration's proposals for amending the Older Americans Act of 1965 will provide State and Area Agencies and tribal leaders with the flexibility that will allow them to strengthen their systems, to make them visible, easily accessible, and responsive to the needs of older Americans, particularly the most vulnerable. I would like to describe now some of the major features of the Administration's proposals for amending the Older Americans Act of 1965.

First, we propose that State allotments be based on population age 65 and over. The bill would amend the formula for allotments to states from appropriations under Title III of the Act to base allotments on population age 65 and older. The formula under the current law is based on population age 60 and over.

States' authority to provide services to individuals age 60 and over would remain unchanged. The Administration is committed to a strategy of targeting resources on those who are most in need of services and benefits available under the act.

This proposal is intended to focus greater resources on persons who are no longer in the work force or no longer have working spouses because it is these persons who are most likely to be experiencing reductions in income, changes in health status, or other life changes which increase vulnerability.

HOLD HARMLESS

The bill proposes eliminating the hold harmless provision of the Older Americans Act which was enacted when it was anticipated that appropriations for each future year would exceed those for the preceding year.

Its apparent purpose was to prevent a state's allotment from declining while the Act's appropriations were increasing. Our proposal would ensure that funds are awarded in accordance with the actual aging demographics. States with larger older populations would get funds in direct proportion to their population; less funds would go to those States whose aged populations have declined.

Optional sliding scale fees for supportive services. Our bill would permit states, at their option, to permit Area Agencies to charge fees, based on ability to pay, for supportive services under part B of Title III. The State agency would be required to assure that no fees for such services would be charged to low income individuals. It would be left to the State's discretion to determine which supportive services would be subject to charges.

As in current law, there would be no authority to charge fees for nutrition services under part C of Title III. This amendment would help ensure the most effective use of limited program funds, because fees collected from those able to pay would enable Area Agencies to expand the services available to those unable to do so. Area Agencies would remain free to seek only voluntary contributions. However, this proposal would complement that authority.

STATE MATCHING FUNDS FOR THE OMBUDSMAN PROGRAM

The bill would require States to provide 15 percent matching of Federal funding for long-term care ombudsman activities under the State plan. This is the same matching share as required for all other State administrative activities.

STATE PLANNING AND SERVICE AREAS

The bill would permit any State, with the approval of the Commissioner, to become a Statewide Area Agency, or the area agency for some or all of the State's planning and service area. The bill would allow Area Agencies to have planning and service areas of much more reasonable sizes.

REQUIRED ASSURANCES FOR EXPENDITURES ON SPECIFIED SERVICES

The bill would eliminate the requirement that area plans provide assurances that an adequate proportion of the area's funds for supportive services and senior centers will be expended for the delivery of specified priority services, and would substitute a requirement to expend some funds for one or more of the priority services.

Enactment of this proposal would provide greater flexibility and discretion by allowing State and Area Agencies on aging to shift more of their resources toward developing community or family service systems which would better serve the most vulnerable elderly and their families.

TRANSFER OF FUNDS

The bill would increase the portion of allotments that States may transfer between supportive services and nutrition services sections of Title III from 30 percent under current law to 50 percent for fiscal year 1988, 60 percent for fiscal year 1989, and 75 percent for fiscal year 1990. Enactment of this proposal would allow State and

Area Agencies greater flexibility and discretion in the use of Title III resources in response to the needs of older individuals.

DEMONSTRATION WAIVERS

The bill would authorize the Commissioner to waive compliance with any requirements of Sections 305, 306, and 307 of the Act in the case of demonstration projects promoting the objectives of Title III.

Section 308(a)(1) of the Act currently provides State agencies with the authority to carry out demonstration projects of statewide significance relating to the initiation, expansion, or improvement of services assisted under Title III. However, State agencies are often hampered from undertaking effective demonstrations of comprehensive and coordinated systems because of the various requirements in the current law.

If the act provided the authority to waive several of the current requirements, State and Area Agencies could begin to develop and demonstrate community service systems to appropriately sustain vulnerable older people in their communities and in their homes.

STATE PLAN ADMINISTRATION

The bill would repeal the authority of States, upon application to the Commissioner, to use for State plan administration an additional three-quarters of one percent of their allotments under Title III. The proposal would assure that funds under Title III are primarily used for the purposes intended, namely the provision of nutrition and social services to the elderly.

MAINTENANCE OF EFFORT

The bill would repeal the requirement that a State's allotment for any fiscal year be reduced by the percentage by which its expenditures from State sources from that fiscal year are less than such expenditures for the preceding year. The current requirement has the unintended effect of discouraging one-time expansion of State programs in response to temporarily increased need or from non-renewable funding sources.

AMENDMENTS TO TITLE IV, TRAINING, RESEARCH AND DISCRETIONARY PROJECTS AND PROGRAMS

The bill would simplify and streamline Title IV and remove unnecessary provisions in the categories of training, research and discretionary programs. Further, our bill would eliminate barriers to participation by for-profit entities. The proposal would also eliminate some of the elaborate, lengthy descriptions of areas of innovation.

Additionally, the removal of the prohibition against the transfer of Title IV funds would allow for more effective coordination and cooperation with those Federal agencies or departments proposing to establish programs and services substantially related to the purposes of the Older Americans Act. This coordination and cooperation is mandated under Section 203 of the law.

AMENDMENTS TO TITLE VI, GRANTS FOR INDIAN TRIBES

The bill would repeal the provision requiring, as a condition of eligibility of an Indian tribal organization for a grant under Title VI of the act, that individuals to be served by the tribual organization could not receive in the same year services under the State grant program under Title III.

The current law has an unintended effect. It can result in making ineligible for Title III services an older Indian who could be served by a Title VI grant but is not being served, or to make the older Indian who receives only one type of service under Title VI ineligible for any other services under Title III.

Our proposal would permit older Indians who are 60-plus and members of tribes who have received Title VI funds to be eligible to be served by Title III programs along with non-Indian older individuals who are eligible.

Mr. Chairman, having served in the aging network since 1972 I can see its maturity. It does not require the amount of federal intervention or direction that it did 21 or even three years ago. Our proposals are consistent with the Administration's policies to place emphasis on services to those most in need, to maintain services, and to provide for technical assistance and other support to State and Area Agencies on Aging, and to tribal governments and their leaders.

Our proposals are also consistent with the policy to return decision-making to the level nearest to the people. This Administration is deeply committed to improving the quality of life for all of this nation's older citizens. We appreciate this opportunity to share with the subcommittee information about some of our efforts and to present our suggestions for improving and expanding the provisions of the Older Americans Act in order to assure that we address the needs and concerns of older Americans now as well as in the future.

This concludes my prepared summary remarks. Copies of my full statement have been made available, and I would request that the full statement be included in the record. I would be happy now to respond to any questions which you or other members of the subcommittee may have. Thank you.

[The prepared statement of Mrs. Fisk follows:]

STATEMENT BY

CAROL FRASER FISK
COMMISSIONER ON AGING
ADMINISTRATION ON AGING

BEFORE THE
SENATE LABOR AND HUMAN RESOURCES
AGING SUBCOMMITTEE

APRIL 23, 1987

Mr. Chairman and Members of the Subcommittee, I am pleased to have the opportunity to discuss with you today the reauthorization of the Older Americans Act of 1965. WE SUPPORT REAUTHORIZATION, AND I CAN ASSURE YOU OF BOTH MY PERSONAL COMMITMENT AND THAT OF THIS ADMINISTRATION TO A STRONG, VIABLE, AND RESPONSIVE OLDER AMERICANS ACT.

I believe that the Older Americans Act passed by the Congress more than 21 years ago this past July is one of the most important pieces of legislation for older persons ever passed. The Older Americans Act has been enormously successful in serving this nation's rapidly growing older population, and I am proud to have served in Older Americans Act funded programs since 1972.

In 1965 the appropriation level was only $7.5 million. In FY 1987, the Older Americans Act appropriations total $724.5 million. As you are aware, AoA annually awards grants to States to foster the development of comprehensive and coordinated service systems to serve older Americans in order to: "... (1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services; (2) remove individual and social barriers to economic and personal independence for older individuals; and, (3) provide a continuum of care for the vulnerable elderly."

The Administration on Aging is very proud of the contributions made by the national network on aging to improve the quality of life for older Americans with both the supportive and nutrition services authorized by the Older Americans Act.

Title II of the Older Americans Act establishes the Administration on Aging (AoA) as the principal Federal agency for carrying out the provisions of the Act. This Title also describes the basic roles and functions of AoA. Chief among these are to administer the programs authorized by Congress under Titles III, IV, and VI of the Act, and to serve as an effective and visible advocate for older persons within the Department and with other agencies and organizations.

The Title III program has evolved from a relatively simple program of community service projects for older persons into a complex and highly differentiated "national network on aging" currently consisting of 57 State Agencies and 670 Area Agencies on Aging and more than 25,000 local nutrition and supportive service providers.

Not only do the State and Area Agencies on Aging use Title III monies to provide services but they also are instrumental in leveraging other public and private monies (for example, other State and local funds, private foundation contributions, and other Federal funds) in supporting the needs of older persons.

The Title III activities conducted in the States are based upon two, three, or four-year plans, as provided for by the 1981 amendments. Three separate Title III allocations are made to the States for (a) supportive services and senior center operations; (b) congregate nutrition services; and (c) home-delivered meals.

Each State makes awards to the Area Agencies, based upon their approved area plans, to pay up to 85 percent of the costs of supportive services and senior centers and for nutrition services. In most cases, Area Agencies then arrange with public, nonprofit, and/or proprietary service providers to deliver nutrition and other services described in the area plan. AAA's themselves monitor these services, plan for future needs and serve as advocates and leaders on behalf of all older persons in their planning and services area.

Before I begin our discussion on the reauthorization of the Older Americans Act, I would like to report on some of the leadership and advocacy activities of AoA. Many of the ideas and experiences gained from these activities have been used to develop the Administration's bill which I will share with you today.

As AoA begins the third decade of administering the OAA, we are undertaking a critical examination of not only what has been accomplished but also what remains to be done. We must operate within the framework of the changing demographics of the elderly (as well as of the families of which they are a part) while still ensuring that the nation's neediest elderly persons continue to receive the assistance they require to remain self-sufficient and independent within their own communities.

Two critical issues are emerging which necessitate an intensive examination and reassessment of AoA programmatic and discretionary priorities now and in the years ahead. One challenge, of course, is the rapid growth of the elderly population. Between 1980 - 2000, the population age 60 and over is expected to increase approximately 27 percent and to represent 17 percent of the U.S. population. This may climb to more than one in four persons by the year 2030 -- nearly 82 million older persons. This "graying" of American society will have a significant impact upon every major social institution -- particularly social services -- in the decades ahead.

A second major challenge will be to focus our increasingly scarce public resources on those older persons most in need of assistance. Frequently, these persons -- the most vulnerable -- are women, minorities, low income persons, and the very old.

Beginning FY 1986, and for the next several years, the Administration on Aging is embarking upon more aggressive efforts to assist vulnerable older persons and their families in finding appropriate help to maintain their independence within their own communities and to delay or prevent unnecessary institutionalization.

For this to occur, Mr. Chairman, I believe communities must take positive action to build integrated and responsive systems of care. The Area Agency on Aging is the key organization that must continue to forge linkages with and between existing systems of services within each community in their area of responsibility and where necessary, provide leadership in helping communities develop new services, organizations and linkages. AoA is working with State and Area Agencies on Aging to strengthen efforts that will build a system of services to provide a continuum of care for older persons within each American community. Each system must, in turn, be tailored to meet the special needs, circumstances and resources of each individual community.

For example, in order to help States and Area Agencies in the development of responsive community-based systems, AoA has developed a guide. This guide can be used by leaders and citizens of every community in the nation to assess their local systems and to determine if current systems at the local level are responsive to the needs of older people. The guide can be a useful tool in heightening awareness of community responsibility for the special needs of the elderly and of the necessity of forging systems of care that are appropriate to an individual elderly person's needs, capacities and resources.

To meet the challenges facing it, AoA is committed to working for increased responsiveness by families, States and communities, service providers, and the private sector to the current and future needs of older Americans. In addition, AoA is committed to building more positive attitudes and perceptions of aging and the aged.

Two of AoA's most important priorities in fiscal years 1986-89 are:

(1) to assist families in their efforts to care for older relatives, particularly the most vulnerable and frail, and to help maintain these older persons in their homes and communities as long as possible; and

(2) to assist States and communities in their efforts to develop and improve community-based systems of care that are accessible, appropriate, responsive, cost-effective and humane.

To achieve these priorities, AoA will initiate, encourage and supplement activities designed to help Area Agencies on Aging:

- increase their visibility to those who most need access to services and to serve as a catalyst and broker of services to the elderly in their own communities;
- serve as a focal point for coordinating aging services within communities, working with other systems to help provide a continuum of care and tailoring local service systems to meet the needs and special circumstances; and

- o improve the targeting of services to the most vulnerable and frail elderly and their families in order to help communities serve as many older persons as possible to remain independent and self-sufficient for as long as possible.

The strategies which AoA will use to accomplish the long-range objectives and program priorities include:

- o strengthening linkages with and between other agencies at all levels, both public and private, which serve the elderly;
- o increasing transfer of knowledge about models of family and community-based care systems to appropriate organizations and service providers;
- o heightening public awareness of the role individuals play in determining their own health; and
- o promoting public awareness in a variety of areas, including the availability of State and local aging services agencies to help older persons.

Toward this end, AoA has developed and implemented a variety of special initiatives aimed at improving the quality of life for older people. Examples of special initiatives are as follows:

- Two years ago the Administration on Aging launched a national initiative to assist State Agencies on Aging to develop and implement strategies to increase minority participation in Older Americans Act programs. This initiative was undertaken in cooperation with the State Agencies on Aging, Regional AoA Offices and four national minority organizations: Asociacion Nacional Pro Personas Mayores; National Center on Black Aged; National Pacific/Asian Resources Center on Aging; and the National Indian Council on Aging.

  In addition, each State was asked to prepare an action plan which described steps the State proposed to take through FY 1985 to increase minority participation. A summary of models for minority participation activities was transmitted by AoA to the aging network and we expect the States to replicate some of these models.

- AoA has long realized the need for the systematic sharing of technical information among members of the aging network about projects and efforts which benefit older people. During FY 1986 AoA began publication of Aging Program Notes, which is regularly sent to the aging network and features descriptions of success stories from State and Area Agencies on Aging that have demonstrated their effectiveness as focal points in their communities.

- As part of its plans for more aggressive efforts in assisting vulnerable older persons and their families, AoA has also realized that the aging network needs to be more visible. During FY 1986, AoA completed two tasks which will bring about greater visibility of State and Area Agencies on Aging. As many of you may recall, AoA forwarded to Senators and Congressmen a list of their State and Area Agencies on Aging and asked them to tell those who are concerned about older people that the State and Area Agencies on Aging are there to help. We urged them to contact their respective State and Area Agencies on Aging with questions about services and programs for older people. In addition, AoA worked with the the Social Security Administration to distribute copies of the

AoA Directory of State and Area Agencies on Aging to each of its district offices. This will encourage appropriate referrals to services to take place for older persons, their family members and caregivers.

- Recognizing the personal and societal benefits of healthier lifestyles for older persons, AoA and the Public Health Service (PHS) have undertaken a multiyear effort to encourage States and local communities to develop ongoing health promotion and wellness activities for older Americans. The goals of the initiative include: (1) enhancing the quality of life for older Americans through improvement of their health status; (2) focusing attention on health promotion and disease prevention, especially in the areas of injury control, nutrition, physical fitness, and drug management; and (3) reducing health care costs caused by preventable conditions. This initiative also incorporates a commitment between PHS and AoA to ensure a gerontological focus in the curricula of various health care professionals in order to prepare the health community of this nation for the graying of America.

- Under its multiyear Alzheimer's disease initiative, the Administration on Aging has supported several research and demonstration projects designed to develop and strengthen family and community-based care for Alzheimer's disease victims. AoA also has joined with other Federal agencies in coordinating our current and planned discretionary program efforts aimed at meeting the supportive service needs of Alzheimer's disease patients and their families. This includes collaboration with the National Institute of Mental Health in sharing information about respective demonstration and research program activities in the field of Alzheimer's disease to minimize duplication in efforts to strengthen family and community supports, as well as collaboration with the National Institute on Aging to exchange information on current and planned efforts for Alzheimer's disease patients and their families. AoA consequently included a special priority area for demonstration grants under the FY 1987 OHDS Coordinated Discretionary Funds Program designed to strengthen the leadership capacity of State Agencies on Aging to assist Alzheimer's disease victims and their families. It should be noted that while many persons with dementia are served and will be served by these research efforts, many more are served through the regular programming of Title III.

- During FY 1986, AoA actively promoted and disseminated information about home equity conversion for State and Area Agencies on Aging and other organizations interested in the elderly. Efforts were made to identify useful home equity conversion products, disseminate useful products and materials, sponsor workshops at the regional level to promote interest, and provide technical assistance to potential home equity conversion sponsors. Under this initiative several new products were distributed. These include: the proceedings from "The Future is Now--A Home Equity Conversion Conference", jointly sponsored by the Department of Housing and Urban Development, the Federal Council on the Aging and AoA, and An Attorney's Guide to Home Equity Conversion, designed to facilitate research by attorneys regarding legal issues involved with home equity conversion, developed by the American Bar Association under a grant from AoA. The guide was distributed to several groups including legal services attorneys and private attorneys who serve older people and others. A manual, Home Equity Conversion--Information and Actions for the Aging Network, also was disseminated to AoA Regional Offices.

o In FY 1986, AoA awarded nine (9) new grants to demonstrate Statewide collaborative activities to prevent and treat elder abuse. As part of the work being undertaken through these projects, State and Area Agencies on Aging and State adult protective service agencies are working with the courts, law enforcement officials, consumer protection agencies and voluntary groups to: (1) conduct public awareness campaigns to recognize and prevent elder abuse; and (2) coordinate action for intervening and following up on elder abuse reports. The projects will produce various "how-to" manuals, video tapes, training conferences, public service spot announcements for radio and television broadcasting, publicity and informational materials, and model Tribal codes.

- As part of AoA's strategy to target services to the vulnerable elderly, the Agency has launched an initiative to improve the capacity of caregivers who provide critical assistance to functionally impaired older persons. This initiative is based on the recognition that growing numbers of vulnerable older persons in this country are cared for in their homes by family, friends, and neighbors, and that these caregivers often have insufficient information, training, and support to perform their roles in a fully effective manner. During FY 1986, AoA funded 22 research and demonstration projects to develop model Statewide and local dissemination campaigns to inform and educate caregivers about the most useful ways of carrying out their difficult tasks. The projects will implement 19 Statewide and 23 local campaigns using television, film, videotapes and telecommunications in innovative ways to reach the broadest possible audience. A project funded in FY 1985 established a national newsletter for caregivers called Parent Care. Over 600 paid subscriptions had been received by the end of FY 1986 and the project expects to become self-sufficient during FY 1987. As part of the caregiver initiative and AoA's long-term care activities, AoA developed a generic caregiver brochure. This brochure is designed to provide information to informal caregivers of vulnerable older people - particularly to caregivers and concerned relatives who may live in a different part of the country than the older person. We have been working with a large number of private sector groups to have them reproduce and distribute this guide.

AoA has not been alone in working to improve the lives of older Americans. The 1981 and 1984 Amendments to the Act provided greater flexibility to State Agencies on Aging, and they have begun to use that flexibility.

For example, State Agencies on Aging used Title III-B (Supportive Services) funds and funds from other sources to establish and maintain long-term care ombudsman programs at the State and sub-State levels. Additionally, through their ombudsman programs, States have addressed such issues as nursing home regulations, abuse of residents' personal funds, and restrictions on access to nursing homes. During FY 1986, complaint statistics and ombudsman program data for the FY 1985 reporting period were analyzed. Some highlights of these data are as follows:

- The number of sub-State ombudsman programs reported by States continues to increase. During FY 1985, the most recent period for which data are available, there was a net increase of 53 local or regional ombudsman programs, increasing the nationwide total from 679 in FY 1984 to 732 in FY 1985.
- Total funding for State and local ombudsman programs in FY 1985 was about $18.5 million, an increase of 29 percent over FY 1984. In addition to Title III-B funds, State and local governments used funds from other sources, including State, county, and local revenues and other funding sources.
- Nationwide, over 8,900 people worked in State and local ombudsman programs during 1985, including professional and volunteer staff.

Data on Title III services and program operations are sent to the Administration on Aging each year by the State Agencies on Aging through the Title III Information System. During FY 1986 the Title III Program Performance Reports for FY 1985 were analyzed. Selected program data are highlighted below.

- The Title III-B program is currently reaching an estimated nine (9) million older clients in need of access, in-home and community-based services.
- In FY 1985, 16.4 percent of all participants were racial and ethnic minorities and 43 percent were low income.
- In the area of access services, transportation was the most frequently provided service, followed by information and referral and outreach. Of four defined in-home service categories, reassurance to elderly persons through visiting and telephone contacts was reported most frequently, followed by homemaker, chore and home health aid services. Of the four service categories reported in the Title III Information System, health services were most frequently provided, followed by legal, escort and residential repair/renovation services.

- Over 149 million congregate meals were served to older people and their spouses during FY 1985. In addition to Title III funds, these meals are also supported by State funds, Social Services Block Grant and other Federal funds, State and local funds and participant contributions. Over 2.9 million elderly received meals at congregate sites. During FY 1985, 75.5 million meals were provided to the homebound elderly from all funding sources. Approximately 670,000 older persons received these meals.

Under Title VI of the Older Americans Act, the Administration on Aging annually awards grants to Federally recognized Indian Tribes. These grants assist Tribal Governments in delivering nutrition and supportive services to older Indians. In FY 1986, the number of Tribes funded under Title VI increased from 125 to 133.

In January 1986, Regional Offices of the Administration on Aging were authorized to serve as the primary point of contact for Indian leaders operating programs for the elderly. By virtue of long experience with Older Americans Act programs, familiarity with community resources and geographic proximity, the Regional Offices have successfully provided management assistance and opportunities for collaboration between Indian leaders and State officials working in the field of aging.

During FY 1986, Title VI service data were analyzed for the FY 1985 funding period. Preliminary analysis of the data reflects the following:

- The Title VI program continues to maintain a very high participation rate. Of the eligible population of 28,417, about 90 percent participated in nutrition services and about 60 percent received one or more supportive services.
- About 70 percent of the older Indians participating in nutrition services received their meals in a congregate setting, while 30 percent received their meals at home.
- Title VI provides a wide variety of supportive services. The two services most frequently used are transportation and information and referral.
- The Title VI program attracts a large number of volunteers (about 60 percent of staff) to assist with the program.

- The level of effort continues to be directed primarily toward nutrition services. Approximately 60 percent of Tribes' total expenditures are for meals.

Title IV of the Older Americans Act authorizes a program of discretionary grants and contracts to support training and education, research and demonstration and other activities. A total of $23,925,000 was available to support those efforts during FY 1986. Over the next three years AoA will encourage and fund Title IV activities that will further assist State and Area Agencies on Aging in the development of more coordinated comprehensive and responsive systems dedicated to helping older individuals to remain independent in their communities. AoA's goals for these activities are outlined below.

- Assessments of Community Service Systems and the Roles of Area Agencies on Aging -- Improvement in community-level service delivery systems for the elderly is a key priority for AoA over the next three years. An instrument which assesses both the status of community service systems and the roles of Area Agencies on Aging in furthering their development was produced several years ago. However, it has not been widely used and there is, consequently, only anecdotal information on these topics. Through the FY 1987 Coordinated Discretionary Program announcement, AoA plans to fund multi-site demonstrations in several States to encourage State Units on Aging to begin obtaining information on the adequacy of community-level service systems and the activities of Area Agencies on Aging.

o Development of Measures for Assessing the Performance of State Agencies on Aging -- Agreed-upon measures that can be used by State Units on Aging to evaluate how well they are carrying out their major responsibilities do not currently exist. One priority area in the FY 1987 Coordinated Discretionary Program announcement calls for the development and field testing of just such a self-assessment instrument. What is envisioned is a protocol that can be self-administered and that compels critical analysis of the strengths and weaknesses of State Units on Aging in the performance of their most important functions. Developmental work in this area should result in an instrument which is applicable to all States and which will be sufficiently easy to use so as not to discourage voluntary application on the part of State Agencies interested in formal self-evaluation.

- Measurement of Comprehensive Community Based Systems-Building Efforts of State Units on Aging and Area Agencies on Aging -- Under an award issued in September 1986, the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (NAAAA) will develop a recommended approach for measuring and reporting data on the incidence of community service system-building activities carried out by State and Area Agencies on Aging. NASUA and NAAAA will prepare and field test a set of terms and procedures for reporting information on this area, and will eventually provide a national data service for AoA and others by analyzing the indicators of community systems-building efforts on an ongoing basis.

As you can see, AoA has undertaken the initiative to strengthen the roles of State and Area Agencies on Aging -- as catalysts, information and referral centers and as brokers of services -- to help enhance, not replace, individual self-sufficiency, family care-giving and other traditional forms of community support. The building and strengthening of coordinated community services systems for the elderly and their families is the overall goal of AoA. I believe, Mr. Chairman, that the Administration's proposals for amending the Older Americans Act of 1965 will provide State and Area agencies with the flexibility that will allow them to strengthen existing local systems to make them more visible, easily accessible and responsive to the needs of older Americans, particularly the most vulnerable.

I would now like to describe some of the major features of the Administration's proposals for amending the Older Americans Act of 1965, which Mr. Tauke introduced on April 9, 1987 as HR 2086.

AMENDMENTS TO TITLE II

APPOINTMENTS TO FEDERAL COUNCIL ON THE AGING

The bill would restore, for FY 1988 and succeeding fiscal years, the procedure in effect prior to enactment of P.L. 98-459, the Older Americans Act Amendments of 1984, under which appointments to the Federal Council on the Aging are made by the President with the advice and consent of the Senate.

The major purpose of the Council is to advise and assist the President on matters relating to the special needs of older Americans. Therefore, it is wholly appropriate, as in other matters, that those who will advise and assist the President be appointed by the incumbent of the office.

AMENDMENTS TO TITLE III

STATE ALLOTMENTS BASED ON POPULATION AGE 65 AND OVER

The bill would amend the formula for allotments to States from appropriations under Title III of the Act to base allotments on population aged 65 and over (the formula under current law is based on population aged 60 and over. States' authority to provide services to individuals aged 60 and over would remain unchanged.

The proposal to change the states' formula allotments would direct more funds to States where needs are greater due to larger percentages of older individuals and less funds to States whose aged populations have declined. The Older Americans Act of 1965, as originally enacted, did not fix any age of eligibility for its services, but based allotment formulae for State grants largely upon each State's population aged 65 and over. When the Nutrition Program for the Elderly was enacted in 1972 the age of eligibility for that program was fixed at 60; and in the comprehensive revision of Title III enacted the following year, the Title III formula was changed to relate to each State's population aged 60 and older, instead of aged 65 and older.

The Administration is committed to a strategy of targeting resources on those who are most in need of the services and benefits available under the Older Americans Act. This proposal is intended to focus greater resources on persons who are no longer in the work force or no longer have working spouses because it is these people who are most likely to be experiencing reductions in income, changes in health status, or other life changes which increase vulnerability.

HOLD-HARMLESS

The bill would eliminate the hold-harmless provision of the Older Americans Act which was enacted when it was anticipated that appropriations for each future year would exceed those for the preceding year. Its apparent purpose was to prevent a State's allotment from declining while the Act's appropriations were increasing.

Even in years when it was possible to comply with this requirement, its effect was not desirable, because it required continuance of allotments to some States based on past instead of present realities.

OPTIONAL SLIDING SCALE FEES FOR SUPPORTIVE SERVICES

The bill would authorize States, at their option, to permit area agencies to charge fees, based on ability to pay, for supportive services under part B of Title III. The State agency would be required to ensure that no fees for such services were charged to low income individuals. It would be left to State discretion to determine which supportive services would be subject to charges. As under current law, there would be no authority to charge fees for nutrition services under part C of Title III.

This amendment would help to ensure the most effective use of program funds, as fees collected from those able to pay would enable area agencies to expand services available to those unable to do so. States would have discretion to determine which supportive services should be subject to fees; States might well determine that, for example, no fees should be charged for services such as information and referral or ombudsman services.

STATE MATCHING FUNDS FOR OMBUDSMAN PROGRAM

The bill would require States to provide 15 percent matching of Federal funding for long term care ombudsman activities under the State plan (the same matching share as is required for all other State administrative activities).

A State's use of Title III funds for its ombudsman program is the only use for which matching non-Federal funds are not specifically required. There are grounds for believing that this result was never intended and that it was an oversight to fail to require matching for this use of funds. State and Area Agencies are already expending in excess of $8 million in State and local funds for ombudsman activities. The demand for long-term care services will continue to increase and this proposal would serve to support the continued growth of ombudsman activities.

STATE PLANNING AND SERVICE AREAS

The bill would amend the provision permitting a State agency to function as an area agency. Under prior law, certain States, prior to October 1980, had obtained the approval of the Commissioner on Aging to designate the entire State as a single planning and service area, and to act as the area agency for the single area. Current law permits only those States to designate additional planning and service areas administered by other Area Agencies, and to continue to function as the area agency for the balance of the State. This section of the bill would permit any State, with the approval of the Commissioner, to become a Statewide area agency, or the area agency for some or all of the State's planning and service areas.

This proposal would provide States with the flexibility and capacity to develop more cost-effective methods for the administration of Older Americans Act programs, and to carry out more efficiently their responsibilities to evaluate the need for supportive, nutrition and senior center services within the State and determine the extent to which existing public or private programs meet such needs.

REQUIRED ASSURANCES FOR EXPENDITURES ON SPECIFIED SERVICES

The bill would eliminate the requirement that area plans provide assurances that an "adequate proportion" of the area's funds for supportive services and senior centers will be expended for the delivery of specified priority services (access services, in-home services, and legal assistance), and would substitute a requirement to expend some funds for one or more of the priority services. This section would also make a conforming amendment to eliminate the related requirement that the area agency conduct a public hearinq and obtain a waiver from the State agency before failing to expend funds for any priority service.

Enactment of this proposal would provide greater flexibility and discretion by allowing State and Area Agencies on Aging to shift more of their resources toward developing community or family service systems which would better serve the most vulnerable elderly and their families. The proposed amendment would permit States to capitalize on the characteristics of the existing service system in each planning and service area, to fill service gaps, and to more effectively coordinate with other funding sources, both public and private.

COORDINATION OF COMMUNITY-BASED SERVICES

The bill would require State plans to provide assurances that Area Agencies will facilitate the coordination of community-based services to older individuals residing at home, in hospitals, or long-term care facilities, who are at risk of institutionalization but who could remain in or be returned to the community if community-based services were available.

Coordination of home and community-based services for the vulnerable elderly has become an increasingly important service priority that should be a State plan requirement and a mandated area agency activity. Area agencies are in a unique position to provide leadership in coordinating the wide range of health and social services needed by vulnerable elderly persons to remain in the community.

TRANSFER OF SUPPORTIVE AND NUTRITION SERVICES FUNDS

The bill would increase the portion of allotments that States may transfer between the supportive services and nutrition services programs from 30 percent under current law to 50 percent for FY 1988, 60 percent for FY 1989, and 75 percent for FY 1990.

Although some States have used the flexibility provided in the 1984 amendments to transfer funds between parts, enactment of this proposal would provide greater flexibility and discretion and would allow State and Area Agencies on Aging to (1) develop community or family service systems which better serve the vulnerable elderly and their families, (2) encourage all relevant agencies to continue and increase the redirection of resources to serve the most vulnerable elderly, and (3) provide State and Area Agencies on Aging with a clear message that flexibility is intended and allowed in the development of new and alternative ways of coordinating and building comprehensive service delivery systems to address the needs of older individuals.

DEMONSTRATION WAIVERS

The bill would authorize the Commissioner to waive compliance with any requirements of sections 305, 306, and 307 of the Act (relating to State program organization, area plans, and State plans) in the case of demonstration projects promoting the objectives of Title III.

Section 308(a)(1) of the Act currently provides State agencies with the authority to carry out demonstration projects of Statewide significance relating to the initiation, expansion, or improvement of services assisted under

Title III. However, State agencies are hampered from undertaking effective demonstrations of comprehensive and coordinated systems because of the various requirements in the current law. Further, various provisions of the Act preclude State agencies from developing viable demonstration models that do not conform to the planning and service area/area agency service delivery model currently required by the Act. If the Act provided the Commissioner with the authority to waive several of the current requirements that are associated with the planning and service area/area agency service delivery model, State and Area Agencies could begin to develop and demonstrate community service systems to appropriately sustain vulnerable older people in their communities and in their homes.

STATE PLAN ADMINISTRATION

The bill would repeal the authority for States, upon application to the Commissioner, to use for State plan administration an additional three-fourths of one percent of their allotments under Title III for supportive and nutrition services.

The proposal would ensure that funds are primarily used for the purpose intended, namely the provision of nutrition and social services to the elderly.

MAINTENANCE OF EFFORT REQUIREMENT

The bill would repeal the requirement that a State's allotment for any fiscal year be reduced by the percentage by which its expenditures from State sources for that fiscal year are less than such expenditures for the preceding fiscal year. This requirement has the unintended effect of discouraging one-time expansions of State programs in response to temporarily increased need or from nonrenewable funding sources.

The maintenance of effort concept in section 309 of the Act has served as a disincentive to States for using one time funds available to them for the purpose of improving services and systems funded in whole or in part with Older Americans Act funds. We do not think that the statutory requirement in section 309(c) was intended to penalize States that choose to increase their expenditures from State sources above those amounts required for the non-Federal share applicable to allotments received under Title III.

AMENDMENTS TO TITLE IV

TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS

The bill would simplify and streamline the provisions authorizing training, research, and discretionary programs and projects under Title IV of the Act, and would eliminate barriers to participation by for-profit entities in activities under that title.

As it presently reads, Title IV is restrictive. The proposal would eliminate the elaborate, verbose description of areas of innovation to which the Commissioner must give special consideration in making demonstration project (model project) grants. It would also enhance the capacity of State and Area Agencies on Aging to assure the development of local service delivery systems that assist in the provision of family and community based care.

There may have been justification for separate sections on these subjects when these sections were added to Title IV in 1978. However, the special emphasis provided by these sections has served its purpose. Any additional attention these subjects might need could still be given under the general demonstration project authorization.

The removal of the prohibition against the transfer of Title IV funds would allow for more effective coordination and cooperation with those Federal agencies or departments proposing to establish programs and services substantially related to the purposes of the Older Americans Act. This coordination and cooperation is required under section 203 of the Act.

AMENDMENTS TO TITLE VI

GRANTS FOR INDIAN TRIBES

The bill would repeal the provision requiring, as a condition of eligibility of an Indian tribal organization for a grant under Title VI of the Act, that individuals to be served by the Tribal organization not receive in the same year services under the State grant program under Title III of the Act.

The current law also has an unintended effect. It can result in making ineligible for Title III services an older Indian who could be served by a Title VI grant but is not being served, or to make the older Indian who receives only one type of service under Title VI ineligible for any other services under Title III.

This proposal would permit older Indians who are 60-plus and members of tribes which have received Title VI funds, but who may not be served by programs conducted with those funds, or who may not be fully served by such programs, eligible to be served by Title III programs along with non-Indian older individuals who are eligible. This change would also assist tribal organizations and Area Agencies to broaden the scope of their cooperation in developing more comprehensive service delivery systems.

REPEAL OF TITLE VII

OLDER AMERICANS PERSONAL HEALTH EDUCATION AND TRAINING PROGRAM

The bill would repeal the Older Americans Personal Health Education and Training Program under Title VII of the Act. This authority, which has never been funded, duplicates other programs addressing the same needs.

Since Title VII was added to the Act in 1984, no funds for that title have been appropriated. Recent surveys conducted by the AoA Regional Offices indicate that at least $4.6 million is currently being expended in this area from titles III and IV funds and State, local and private sources. These dollar figures were compiled with only 40 States reporting data and nine of these States could not provide dollar information. Since more than adequate emphasis is already being given, without Title VII, to health and nutrition education for the elderly, no useful purpose is served by retaining the title in the Act.

In summary, the "AGING NETWORK" has come of age, and in our opinion does not require the amount of Federal direction or intervention it did 21 or even three years ago. The Department's bill is consistent with the Administration's policies to place emphasis on services to those most in need, to maintain services, and to provide for technical assistance and other support to State and Area Agencies on Aging. The bill is also consistent with the policy to return decision-making to the level nearest the people.

This Administration is deeply committed to improving the quality of life for all of this nation's older citizens. We appreciate this opportunity to share information about some of our efforts, and to present our suggestions for improving and expanding the current provisions of the Older Americans Act to address the needs and concerns of older Americans now, as well as in the future. Mr. Chairman, this concludes my prepared remarks. I will be happy to respond to any questions which you or any of the other subcommittee members may have.

Senator **Matsunaga**. Thank you very much, Mrs. Fisk. I wish to acknowledge the presence of the ranking minority member of the subcommittee, Senator Cochran. Do you have any opening statement?

Senator **Cochran**. Mr. Chairman, I do not have a statement at this time except to thank you for continuing our aggressive hearings looking into all aspects of the Older Americans Act, and particularly how minorities are affected by the administration of the act as it is now drawn.

I think we are going to learn a lot from the witnesses who will appear before the committee today. I congratulate Ms. Fisk for her statement and look forward to hearing from other witnesses as we go forward this afternoon. Thank you very much.

Senator **Matsunaga**. Thank you very much, Senator Cochran. Mrs. Fisk, would not your proposal to allot funds to States based on the population of 65 years and older, rather than 60 and older, raise the probability that a state would reduce or eliminate services to persons between the ages of 60 and 65?

Mrs. **Fisk**. That is certainly not an intended effect. The allotment of dollars is intended to focus on those individuals we believe to be most in need because, as statistics have shown, living longer generally means that individuals are in greater need.

The State would still be advocating for and providing services to anyone over the age of 60. We are not proposing the change in the age for eligibility for services.

Senator **Matsunaga**. But you do see the possibility, if not even a probability. My next question is, what would you do to prevent such a move on the part of the states?

Mrs. **Fisk**. I think that our role would be to encourage and to remind the States that they have responsibilities for all older people. I do not think that that is going to be a problem. In fact, I think that States are extremely sensitive to the needs of all older people and will continue to be that way.

Senator **Matsunaga**. As you know, minorities tend to have a shorter life span, as the statistics will show in the case of native Hawaiians, for example, and native American Indians. Now, because of this shorter span, would the minority elderly be affected more than the others under your proposal?

Mrs. **Fisk**. I see no reason to assume that that would be the case. We would continue to place major emphasis, as we have, on technical assistance, on training and on service delivery designed to assure that the service dollars go to those individuals most in need. And that would include major emphasis on minority individuals throughout the program.

States would still have that responsibility and the change in the allotment formula will not in any way negate the responsibility that they have to serve those in greatest economic and social need with particular emphasis on low income and minority older persons.

Senator **Matsunaga**. You have indicated that states and area agencies should strengthen their efforts to assist the vulnerable and frail elderly. Does this mean that you would like to see more emphasis on community based long-term care services in the future?

Mrs. Fisk. We are interested in assuring that there is a range of services available in the community for all older people. The law is very clear that the breadth of responsibility is, indeed, for all older individuals. We certainly do agree that services must be targeted on the most vulnerable older population. In those communities where there are not adequate community based long-term care services, we are encouraging the State and Area Agencies not only to use the service dollars under the Older Americans Act to address of those needs but also to galvanize the whole range of resources and forces in the community.

We have developed a community checklist designed to focus on the range of needs and the range of resources that need to be brought together at the community level. I would welcome the opportunity to share that with the Senators to show the attention that we believe is appropriate for long-term care needs as well as for the full range of services that should be available in each and every community in our nation. I will submit a copy of the checklist for the record.

Senator Matsunaga. Does this mean that States and Area Agencies would place more emphasis on health related services?

Mrs. Fisk. I am not sure that I can answer that. I think States and Area Agencies are very sensitive to the range of needs of older persons. We were seeing a shift in the way dollars are spent under the Older Americans Act to provide more in-home services and to provide more home delivered meals. Some of those dollars are related to home health services, but most of those dollars are used for meals as well as for supportive social services.

Senator Matsunaga. Now, Mrs. Fisk, with respect to the Administration's proposal to increase State's authority to transfer funds between supportive and nutrition services. Do you have any data which would indicate how many States currently are transferring the maximum 30 percent?

Mrs. Fisk. Well, 38 States transferred some dollars, and five States are above 15 percent. We do have the detailed figures I do not carry them in my head.

Senator Matsunaga. Could you submit it for the record?

Mrs. Fisk. We would be glad to provide them to the subcommittee, yes, sir.

[Information supplied for the record follows:]

COMMUNITY CHECKLIST FOR AN AGING AMERICA

All older people should be able to live independent and dignified lives in their own community for as long as possible today and in the future. Every community should have a system of services and opportunities to help older people serve and be served where they live. Older people, their family and friends must be familiar with the system and feel that it responds to their needs.

How does YOUR community rate in achieving this goal?

1. Does your community have a visible point of contact where anyone can go or call for help, information or referral on any aging issue? ( )

2. Does this point of contact lead to a range of options or a continuum of care including jobs, leisure activities, volunteer opportunities, suitable housing, in-home services, transportation, quality institutional care and other options? ( )

3. Is this range of options accessible to all older persons--the independent, semi-independent and totally dependent, no matter what their income? ( )

4. Are all resources - public, private, voluntary and personal--committed to supporting the system of options for older people? ( )

5. Does collaborative decision-making between public, private, voluntary, religious and fraternal organizations and older people exist in your community? Are all those concerned with older people working together in your community? ( )

6. Is there special help or targeted resources for the most vulnerable older people, those most in danger of losing their independence? ( )

7. Is there good referral from agency to agency to assure that information or assistance is received, no matter how or where contact is made in the community? ( )

8. Is the system in your community flexible enough to respond with appropriate individualized assistance, especially for the vulnerable older person? ( )

9. Is your response to the aging of our nation tailored to the unique nature of your community? ( )

10. Is there leadership in your community to convene all interested persons, assess needs, design solutions, track overall success, stimulate change and plan community response today and in the future? ( )

For more information, or assistance, contact:

- Your Area Agency on Aging
- Your State Unit on Aging
- **The U.S. Administration on Aging**
  330 Independence Avenue, S.W.
  Washington, D.C. 20201
  (202) 245-0011

Aging America
IT'S EVERYONE'S FUTURE

Transfers Between Title III-B and Title III-C*
As Authorized in Sec. 308(b)(5)(B)
of the Older Americans Act
FY 1986

Transfers from III-C to III-B:

In FY 1986, 31 States transferred a total of $20,569,277 from Title III-C to Title III-B. Of these 31 States, five (5) transferred 15% or more of their Title III-C allotments to Title III-B. The State of Virginia transferred the highest percentage of its Title III-C allotment (20%) to Part B.

Transfers from III-B to III-C:

In FY 1986, seven (7) States transferred a total of $512,923 from Title III-B to the Title III-C. The State of Alabama transferred the highest percentage of its Title III-B allotment (5.7%) to Title III-C.

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* This summary does not include information on transfers within Title III-C, i.e., transfers between III-C-1 and III-C-2.

Senator MATSUNAGA. But none have reached the maximum?

Mrs. FISK. There are several which are close to the limit. Our proposal is designed to send a very clear message to States and Area Agencies that they have the responsibility to use these dollars in a way that responds to the unique needs of their older population. We feel that giving them the full flexibility allows them to strengthen the foundation of services today and to be better prepared for the future.

Senator MATSUNAGA. What do you see as the primary reasons for the apparent decline in minority participation in Title III services over the last several years?

Mrs. FISK. Our statistics do not support any decline. In fact, we see the level of minority participation as well as low income participation remaining stable. We have submitted to Secretary Bowen a report that documents that, and he is considering our findings for submission to both the House and the Senate.

However, we remain concerned about low income and minority participation no matter what the statistics show. We know that more out-reach needs to be done. More special programming may need to be put in place. And, in fact, each and every State in this country has a special action plan that they have developed and are implementing to assure that that level of participation stays the same and is appropriate based on the need of the individual State.

Senator MATSUNAGA. You do not have any figures to show that the participation under Title III has, in fact, decreased?

Mrs. FISK. No, sir. We have reanalyzed the data that we have collected from States from the period from 1980 up until the present. The report that I spoke of indicates that States are primarily reporting to us a level of participation that has remained the same. I am very pleased to report that I have received a number of communications recently that indicate dramatic increases. Certainly there are individual localities where there have been decreases. However, we are urging all States to continue to work to see that level increase because we share your concern and the subcommittee's concern that these dollars go to the most vulnerable individuals among our older population.

Senator MATSUNAGA. Mrs. Fisk, I have heard some reports about the loss of personnel within your administration. How many staff persons has the Administration on Aging lost over the last five years, either by the elimination of slots or through details of AOA staff to other assignments?

Mrs. FISK. I do not have that information with me. However, we can supply you with information about staffing since October, 1982.

Senator MATSUNAGA. Could you provide it for the record?

Mrs. FISK. Certainly.

[Information supplied for the record follows:]

PERSONNEL STAFFING—ADMINISTRATION ON AGING

The administration has maintained a well established policy of reducing the size of the Federal bureaucracy. Because of this effort, the Office of Human Development Services has been under a virtually complete hiring freeze for a number of years. HDS has undergone a 35 percent reduction in total staff in recent years. Almost all of the organizations in HDS have sustained reductions in staffing throughout this time through normal attrition of staff.

Although the Administration on Aging (AoA) has taken a reduction in staffing, so have other organizations in HDS. We have made every effort, and will continue to make every effort, to assign HDS staff resources to ensure that the HDS programs, including those of the Administration on Aging, are well managed in accordance with the requirements of the authorizing legislation.

In this context, 54 positions in the AoA Central office (CO) and 39 positions in the Regional Offices (RO) of the Administration on Aging have been vacated since October 1983. This reflects changes due to retirment resignation from Federal service to take other employment and for other reasons, and transfers and promotions to other positions in HDS and in the Department. This, however, does not mean that the positions currently are vacant; nor would it be correct to infer that all the functions of these positions are not being performed. In addition, three staff members of the CO and one staff member from a RO are currently on detail outside of AoA and three members of the CO staff are on extended leave due to illness.

Senator MATSUNAGA. How have these cuts affected the ability of the Administration on Aging to effectively carry out the mandate of the Older Americans Act?

Mrs. FISK. We endeavor with the staff resources that we have to fully respond to the tremendous tasks that faces us with the aging of our nation's population. I think it is fair to say that we will never be able to do as much as we would like to do. However, with the current staff of 173, I pledge to you my personal commitment to use each and every one of those individuals to their fullest.

We are a smaller group, but certainly a group of dedicated people, and we feel that we use our resources to the fullest.

Senator MATSUNAGA. I fully appreciate that, but no doubt when personnel is reduced, services will suffer. What services in your view have suffered the most because of such reductions you have had?

Mrs. FISK. It is difficult for me to point to specific areas. I think we continue to attempt to make major efforts in all of the five areas that I think of as being important under the Older Americans Act: to be leaders, to be a Federal focal point, to provide advocacy, as well as to focus on program management and on internal management.

It is fair to say that as our staff reduces in size, more and more of our attention must continue to go to the program management, the processing of discretionary grants as well as the allotment of State dollars. But I think that our staff is sensitive, is working to its fullest capacity, and we endeavor to continue to make a major contribution in all of those areas.

Senator MATSUNAGA. We have reports that the minority programs usually are the first to suffer. And in that connection, do you believe that the creation of an Indian Aging Desk would improve services to the elderly Indians?

Mrs. FISK. I think that the responsibility for improving services to older Indian elders lies with the tribal governments and with the State offices. Our job is to provide them support, technical assistance, good opportunities under the discretionary grant program. Our track record, I think, is very good in that regard.

Dr. Joyce Berry, who heads up the Office of State and Tribal Programs, has the special responsibility of assuring that we advocate on behalf of Indian elders. I think we are doing a good job there, and certainly as in all areas, we wish we were able to do more. We have mandated that our Regional Office personnel, particularly in those four regions where the largest tribal governments are located, and where we have the largest number of grantees, become more proactive.

Senator MATSUNAGA. Are you saying that you do not believe that there is any need for an Indian Aging Desk?

Mrs. FISK. I would endeavor to make sure that all my staff are sensitive and responsive to the needs of all minorities and not just the Indian elders. I think that Dr. Berry's office, the Office of State and Tribal Programs, does do a good job in that regard, and her entire office serves as that advocate for Indian elders.

Senator MATSUNAGA. Senator Cochran, do you have questions?

Senator COCHRAN. Thank you, Mr. Chairman. I am very happy to see the Administration supporting the reauthorization of the Older Americans Act. I congratulate you, Ms. Fisk, for the efforts that you are making to see that the act is administered in a sensitive way to help reach those who need benefits that are provided in this program.

We had an earlier hearing at which witnesses testified about some of their day to day experiences in administering the programs authorized by this act. I recall one witness said that he thought there ought to be more people who benefit from the program serving in positions of authority in the administration of program. That sounded to me like a good idea. His suggestion specifically was that a majority of those who are entitled to benefit from the program should make up the Federal Council on Aging. I think that is a good idea, and that all down through the bureaucracy at the state and local level we also ensure that there is participation by those who understand the problems of the elderly because they are the elderly. I think we will benefit from that kind of experience and input into the program. What is your reaction to that? Would that be a problem in your judgment?

Mrs. FISK. We have emphasized with States and with Area Agencies the importance of involving older people in the management as well as in policymaking, advisory, as well as volunteer, capacities. We share your concern, and I think that is a very important one. We note with some interest, however, that more and more of our contacts are coming from the middle-aged caregivers. Therefore, we have focused our attention not only on the older individual who has to be our primary concern and should be in the mainstream of involvement with our programs but also on trying to educate and provide assistance for family caregivers, such as middle-aged family members who very often provide the assistance to keep older people independent and involved in their community. Similarly, our target also extends to the younger age group in hopes that we can educate people to plan better for their later life.

So, while we share your focus and your concern, we want to involve all people of any age in discussions of the aging of our society and in the management of our program with a special emphasis on today's older generation.

Senator COCHRAN. Although I am cosponsoring the bill that has been introduced by the chairman of the subcommittee, Senator Matsunaga, I am also going to be introducing the Administration's legislation so that it will have a fair and full hearing before our subcommittee and will be carefully considered here in the Senate.

I notice there is one provision that you suggest that I can tell you would be very popular among those who are administering the area agencies on aging in my state, and that is described on page 30 of your testimony which you have presented to the committee today. It deals with the required assurances for expenditures on specified services.

We heard testimony from one of our witnesses earlier that to have to allocate a certain percentage of their resources to services that may not be needed or wanted by the elderly community is really unfortunate when there are other services and other needs that therefore have to be shortchanged, given short shrift or no funding at all.

One example was given at our hearing about in-home services which are very popular and very needed, and particularly small towns and rural communities where transportation is a problem. You cannot bring the elderly citizens who are sought to be served by the program to a central place for nutrition assistance or other activities that they might like to participate in.

So what happens is in-home services become very popular. But if at the same time you are supposed to provide a certain percentage to, say, legal assistance to that family that does not need any legal assistance or does not want any legal assistance, then this presents a problem. That was discussed as an example of a problem.

As I understand your suggestion, and the legislation that will be before the committee, there is no requirement that a certain percentage be expended for all of these priority services, but the Area Agency on Aging, the administrators could choose the more important, and could get the input of those who are being served as to which they would prefer, not whether somebody here in Washington prefers that it be spent on some service, but whether the person at the local level feels the need and would like to see some assistance being rendered there. That, to me, makes good sense. Am I reading that correctly? Do I understand?

Mrs. FISK. I think you have enunciated our position very clearly. I would add one additional point to the points that you make so eloquently. It is the level closest to the people that best makes decisions about expenditure priorities. As you have pointed out, that is because they know the needs and because they know the resources as well. In the example that you cite, it may be that in the community there are other dollars for pro bono activities which are being provided in the legal assistance area. That need is basically being met. Therefore using our dollars for in-home services would indeed, make more sense.

Senator COCHRAN. There are separate appropriations being made available here in the Congress for legal services in some of these other activities.

Mrs. FISK. There are certainly State dollars, local dollars and voluntary efforts that go into any one of the service categories that we might think are important for older people. So it is best, we believe, for the Area Agencies and the State units to take a look at the resource mix they have and the needs that they have and make the decisions at that level about the allocation of dollars. We hope that you will look favorably on that proposal.

Senator COCHRAN. I hope that your office will continue to be involved as a spokesman for the Nation's elderly in the area of Social Security. I visited a senior citizens' center during the past week when the Congress was not in session, and there, as always, one of the critical concerns expressed to me is whether or not the Social Security system is sound.

I think it is unfortunate that we have some groups that make a career out of frightening older people into thinking that it is not sound, and that it is about to collapse, or that they are not going to get their checks next month unless they send in ten dollars to somebody who is going to save the system. I mean the point is—and I want to ask you if this is a correct assessment—there is a substantial surplus in the Social Security Trust Fund right now because of changes that were made at the instance of a commission that was formed a few years ago to try to identify problems in the system and fix them. The Congress went through the process of voting on changes, broadening the tax base to support the Social Security system in a fiscally sound way.

I think it is fair to tell those who benefit from Social Security now that the system is sound, and that there is no threat to their benefits under the Social Security system. I am confident that Congress is going to continue to support it. I just hope that your office will also continue to be a very enthusiastic supporter of Social Security, and within the Administration continue to strive to see that everything is done to protect that system.

Mrs. FISK. I appreciate your reminder, and we certainly will do so. We are working right now with the Commissioner of Social Security, Dorcas Hardy, on some joint efforts designed to facilitate greater flow of information to older people through State and Area Agencies. We are also trying to facilitate better linkage of services for those older people who may tell a Social Security claims representative about needs that could be met through a referral to the Area Agency. We are pleased to establish links with the Social Security Administration which we hope will facilitate not only information flow but better services to older people.

We are establishing similar linkage with the Health Care Finance Administration. Dr. Roper also has concerns that older people are not fully apprised of their benefits under Medicare and Medicaid. His agency has done a series of Medicare and Medicaid notes, and we disseminate them. We see ourselves as the advocate but also as the vehicle for disseminating just the kind of factual information that you have identified as being so important for the well-being of older people.

Senator COCHRAN. I think that will be a big help. It will save a lot of older people ten dollars if you will let them know what the answer to that question is. Thanks. Thank you, Mr. Chairman.

Senator MATSUNAGA. Thank you very much, Mrs. Fisk.

Mrs. FISK. Thank you, Senator. We appreciate the opportunity to talk with you and the subcommittee. Thank you.

Senator **Matsunaga**. Mr. Smith, appreciate your coming. Our second panel of witnesses today represents a cross-section of elderly minorities. The first witness will be Dr. David Brown who is the Director of the Mississippi State Agency on Aging. Also appearing before us today will be, Miss Carmela Lacayo, president of the National Association of Hispanic Elderly; Mr. Larry Crecy, vice president of the National Caucus and Center on Black Aged who is presenting the testimony of Mr. Samuel Simmons, president of the NCCBA; Mrs. Iwalani Minton of Eola Mau, an organization of native Hawaiian health care professionals will be presenting the testimony of Mrs. Winona Rubin, Director of the Hawaii Department of Social Services and Housing; and Ms. Louise Kamikawa, Executive Director of the Pacific Asian Resource Center on Aging; and Dr. Arnold Parks, Professor of Sociology at Lincoln University in Missouri.

I want to extend a warm, warm welcome to each of you. Senator Cochran, perhaps you would like to welcome our lead witness from Mississippi.

Senator **Cochran**. Thank you, Mr. Chairman. I am very pleased that our first witness in this panel is Dr. Brown from Mississippi who is Director of our Council on Aging in our State. This is the agency with the responsibility for supervising the administration of the Older American programs in our State. He has done an excellent job. He has served in that capacity for the last several years. He is very well educated, has graduate degrees from New York University and West Virginia University. He has taught at the University of Alabama. He is a specialist in programs relating to the elderly, to human services generally, and we are glad that he is here today, and will be a part of this panel. I welcome you personally and thank you for your assistance, Dr. Brown.

STATEMENTS OF DR. DAVID K. BROWN, DIRECTOR, MISSISSIPPI COUNCIL ON AGING, JACKSON, MI; CARMELA G. LACAYO, PRESIDENT AND EXECUTIVE DIRECTOR, ASOCIACION NACIONAL PRO PERSONAS MAYORES, LOS ANGELES, CA; LOUISE KAMIKAWA, EXECUTIVE DIRECTOR, NATIONAL PACIFIC/ASIAN RESOURCES CENTER ON AGING, SEATTLE, WA; LARRY CRECY, VICE PRESIDENT, NATIONAL CAUCUS AND CENTER ON BLACK AGED, WASHINGTON, DC, ON BEHALF OF SAMUEL SIMMONS, PRESIDENT OF THE NATIONAL CAUCUS AND CENTER ON BLACK AGED; IWALANI MINTON, KENSINGTON, MD, ON BEHALF OF WINONA RUBIN, DIRECTOR, HAWAII DEPARTMENT OF SOCIAL SERVICES AND HOUSING, HONOLULU, HA; AND DR. ARNOLD G. PARKS, PROFESSOR, LINCOLN UNIVERSITY, JEFFERSON CITY, MO

Dr. **Brown**. Thank you so much. It is my privilege to be here. We in Mississippi more than share the national concern over the participation of minority elderly in aging programs, since we rank among the highest in the nation as to the percentage of minority elderly in the state. And, we face the additional challenge of ranking among the highest in terms of elderly at or below poverty. But at the outset, I do also want to thank Senator Cochran and the entire Mississippi delegation for the unstinting support you give us in our program.

The 1984 reauthorization of the Older Americans Act, in my opinion, did some pioneering work in defining the emerging and ongoing role of minority elderly in the program.

I would like to go back and look at several sections of the current bill that are cogent and pertinent to the role that elderly minority play, not only in the receipt of services; but even as important, in participation in the policy and decisionmaking structures of the act itself.

In Section 306, minority elderly sit on advisory boards of area agencies, and the function of the advisory council is to continually advise and have input into that area plan.

The area plan really is the spinal cord of the whole network. It generates the appropriate funds. It lays out the targets and priorities that area agencies strive for during a given year. Minorities have a clear role in organizational capacity building.

Also, in Title IV(B), there is a clear commitment in demonstration projects to look at the particular needs and delivery of services to older individuals and minorities, including Indians and those with limited English-speaking capability. I would remind us of the commitment we made in Title IV(B) with demonstration research into this whole critical issue. Minority elderly are also represented on the Federal Council on Aging, Section 204. Section 6, as you know, holds out the array of services to Indians and tribal organizations. The prohibition in Section 602 against tribal organizations participating in Title III, needs to be looked at very carefully so that we can achieve the kind of cross-integration between Title VI and Title III we spoke of earlier.

In my state, the Mississippi band of Choctaw Indians numbers almost 4,400 people. About 350 of these are 55 and over. That is about 8 percent of the total population. Under Title VI, they routinely receive homemaker, transportation, and senior center activity services. Training and education programs are coordinated with our East Central Area Agency which is in the PSA that includes the territory of the Choctaw Band.

The Choctaws recently completed a demographic survey earlier this year and showed some real problems in low levels of education attainment and limited English-speaking capability. The median age of the tribe is 18 years, which is relatively young compared to the rest of the Nation, but it is my belief the disabilities shared among younger groups impacts upon elderly as well.

The commitment in Title V is very clear, as well, to minority and low income individuals as we seek to place them in opportunities of employment. The authorization also gave the responsibility to the Commissioner to work with national organizations representing minority and low income individuals to develop training and technical efforts that would advise the states, and give states and area agencies policy guidance on how better to understand service delivery systems geared to minority individuals.

The strongest and clearest commitment, however, is in the targeting provisions of Section 305, and I would hope as you consider these that they would certainly be expanded and reinforced. Section 305 fixes responsibility with the state unit to give assurances that preference in providing services be given to individuals with the greatest economic and social need, particularly emphasizing low income, minority individuals.

The procedures for carrying out this mandate are to be vested in the State plan. Section 306 also gives that same targeting responsibility to area agencies on aging, so it is important, as States and Area Agencies bring their plans together, that every effort be made to define, to mobilize and to expand those provisions.

Economic and social need, as you all know, is defined in the act. Social need, particularly, is defined as mental, linguistic, racial or ethnic status which serves as a barrier to the capacity to live independently. I would suggest that we need to understand what that social/economic status factor is among minority individuals if we are seriously to serve the minority community. All of these provisions and mandates form a framework, a context, I believe, that we have to address and expand in the 1988 reauthorization.

It is my firm belief that, as minorities move into planning, decisionmaking, and policymaking positions within the structure of the administration of the network, increased service consumption will follow. And, I hope we could link those two in our discussions. States have wide latitude, as you previously heard the commissioner say, in designing the kinds and types of programs that would enforce and enhance these mandates.

Let me talk a little bit about some of the things we have done in Mississippi to deal with this issue. I have submitted in testimony the results of a Minority Elderly Task Force that we called together last June. You have the full report. They found some interesting things in the report.

Senator MATSUNAGA. Dr. Brown, your written statement presents what you are about to testify to.

Dr. BROWN. That is right, just in summary. It does, sir.

Senator MATSUNAGA. As indicated in our invitation, we have so many witnesses, and you were asked to limit your oral statement to 5 minutes. You have had 10. So I think we will now hear from Ms. Lacayo. As much as possible, try to limit yourself to 5 minutes or thereabout. Just so that you will know when to stop, if you have to, we will try out this traffic light system. When the green is on, you keep going. When the yellow is on, you go like hell, and——

[Laughter.]

[The report referred to follows:]

ATTACHMENT A

MISSISSIPPI COUNCIL ON AGING
MINORITY ELDERLY SERVICES TASK FORCE
FINDINGS AND RECOMMENDATIONS

June 25, 1986

Jackson, Mississippi

HOUSING - MAJOR FINDINGS

Housing is the number one expenditure for most older Americans. They frequently spend about one-third of their income for housing, and a significant percentage spend substantially more, especially low-income older blacks who are unable to live in federally assisted housing.

Many older persons are discovering that they are in practically an impossible housing situation. Rapidly rising energy cost, property taxes and maintenance expenses make it extremely difficult for many elderly individuals to continue to live in their own homes. Yet they cannot find suitable and affordable alternative housing, such as an apartment.

Large numbers of older Americans, and especially older black Mississippians, live in inadequate housing. About two in five are inadequately housed. These figures would be substantially higher under more stringent standards of "adequacy." In rural areas, Black households containing an elderly person were found to be lacking some or all plumbing facilities in 56.6 percent of owner-occupied residences and 85.8 percent of rental units.

While the above facts and figures apply to the nation as a whole, there is every reason to believe that elderly black Mississippians suffer the same fate or may even be much worse in some instances.

RECOMMENDATIONS

The Task Force makes the following recommendations to improve the quality of housing available to elderly Black Mississippians and to initiate and maintain advocacy efforts to support adequate housing and alternative living arrangements.

- Work closely with private sector to promote the "home equity conversion" concept.
- Advocate for funding to maintain and upgrade existing housing stock.
- Provision of consumer fraud prevention types of programs.
- Promote increased Federal-State funding for low-income housing, apartments and single family dwellings.
- Advocate for increased funding for assistance with high utility cost.
- Promote the concept of alternative living arrangments to include: home sharing, match-up, echo housing, and accessory apartments.
- Provision of educational programs that will assist older persons to qualify for special services.

II. ECONOMIC ISSUES - MAJOR FINDINGS

Elderly minorities are two to three times as likely to be poor as elderly whites. Moreover, they frequently experience greater extremes of deprivation. The likelihood of being poor among older Blacks is three times as great as for older Whites. One of the most economically deprived groups in our society today is aged Black women living alone or with nonrelatives. Almost four out of five either live in poverty or so close to it that it makes little difference.

The Task Force identified several barriers perceived as leading causes of poverty among Mississippi's minority elderly. Among these were: Employment - the prevalence of age and sex discrimination; Education - cultural differences, lack of knowledge and sophistication on the part of older minority members, and the general lack of availability of educational programs for older individuals; Cultural Values - lack of positive self image, the need to recondition existing values, reviving family support systems and mass media attention to negative attributes.

RECOMMENDATIONS

To enhance and improve the economic plight of older Black Mississippians, the Task Force recommends the following activities as a framework to serve the needs of older minorities in the future:

- Implement and maintain networking activities with both private and public sectors.
- Provide educational programs on economic issues affecting the black elderly through media presentations, professional journals, Senior and Junior College enrichment programs.
- Encourage support and use of Black businesses.
- Sensitize the business community to the needs and fiscal resources of the Black elderly.
- Advocate for financial incentive, tax write off for family caregivers.
- Support consumer education efforts in the area of "Becoming Credit Wise."
- Creation of new jobs for older women.
- Development of "Self Employment" programs and activities.
- Advocate for training and retraining programs designed for older persons.

III. HEALTH ISSUES - MAJOR FINDINGS

In dealing with health issues the major concerns centered on:

1. Health maintenance or preventive medicine; public education, health promotion, self care;
2. Cost containment, not only for the health facility and provider, but also the elderly person as to out-of-pocket expenses;
3. The need for a national insurance program, which would go beyond the costs covered by Medicare or Medicaid; and
4. Increased awareness of legislative health related issues in Mississippi; a hot line or clearinghouse to mobilize elderly to utilize the political arena to best advantage.

RECOMMENDATIONS

1. Health maintenance and preventive medicine:
   - develop public awareness campaigns.
   - appropriate groups should advocate for state funds for support services.
   - mandate a Minority Elderly Affairs Committee which would meet on a regular basis to address issues of minority elderly.
   - develop a "watch dog" monitoring group which should continuously look at and react to legislation and policy which might affect the elderly.
   - initiate an intensive consumer/education campaign such as nutrition, physical fitness, medication, physician selection, entitlements and benefits.
2. Cost containment:
   - provide extensive information on various Medigap type insurance.
   - provide counseling on insurance in general for persons "under or over" insured.
   - provide medical consumer information and education.
   - utilize alternative health care and delivery systems: i.e. mobile units which would go out to remote areas; screenings being done at senior citizens sites, shopping centers, etc.

- encourage Medicaid waivers for community based or in-home medical services to be expanded statewide.
- administrative review and revision of eligibility requirements for medical entitlements.
- increased funding for community based long term care.

IV. ACCESS - MAJOR FINDINGS:

There is inadequate access to support services with regards to service availability, location, and hours of availability. Major concerns revolve around health and medical needs, ability to pay, education and information and one's ability to get to what is available. Consideration must be given to the following conditions:

- The delivery of federal funded programs and services to older blacks is not always rational and efficient, owing in large measure to the rurality of the state, communication, discrimination, the application of local standards, the imposition of personal or primary group relationships, and the lack of monies to serve all eligible persons.
- Many aged blacks, financially unable to pay the monthly premiums required for full participation in Medicare, are deprived of full coverage.
- Many noninstitutional aged blacks whose health prevents them from carrying out their activities of daily living cannot obtain the home health care, housekeeping aid, meal preparation, and other assistance that they need to maintain themselves adequately in their own residences. This problem is particularly severe for many aged black women who live alone.
- Increase emphasis on education and assistance to promote informal support systems, worthy use of time and involvement, volunteerism.
- Older Blacks miss the mark with regards to legal assistance, i.e. estate planning, consumer protection.

RECOMMENDATIONS:

Promote interagency cooperation and collaboration regarding targeted minority services with agencies administering Medicare, Medicaid, Veterans benefits, Social Security, health and welfare.

Make a sincere effort to target Mississippi Council on Aging funded services, such as outreach, information and referral, Homemaker/Home Health Care, case management, home delivered meals and transportation to older blacks and especially those living in rural communities.

Promote and deliver more health care consumer education including information on general insurance, Medicare/Medicaid/general insurance, supplemental health care insurance policies, long-term care insurance.

Promote and deliver more pre-retirement education for older minorities especially as relates to health maintenance plans.

Promote and deliver more nutritional and health care education for older minorities.

Promote and target health oriented community based service systems to older minorities.

V. ECONOMIC STATUS: AN EPILOGUE

The challenging economic conditions for senior citizens in general can ordinarily be multiplied two or three times for older Black Americans because they suffer from multiple jeopardy since they are old, black and quite often poor. Older Blacks are almost three times as likely to be poor as elderly Whites. Black elderly poverty as a share of the total incidence of poverty has increased over the last decade. Nearly 26 percent of all aged Blacks live in poverty, in contrast to 13 percent for elderly Whites.

Black and Hispanic elderly have substantially lower money incomes than their white counterparts. In 1984, the median income of white men age 65 and older was almost twice that of elderly black and Hispanic men. Among those aged 65to 69, white males had a median income of $12,749 compared to a median income $7,545 for black men and $8,778 for Hispanic men in the same age group. A similar relationship existed between the median income of white males age 70 and older ($9,853) and the median incomes of black ($5,679) and Hispanic ($5,705) males of the same age.

Among women, the differences were less pronounced. The median incomes of elderly black and Hispanic women are generally two-thirds to three-quarters as large as the median income of white women. The median income for white women 65 to 69 years of age was $6,527 compared to $4,446 for black women and $4,342 for Hispanic women of the same age. The median income for white women 70 and older was $6,225 compared to $4,304 for black women and $4,825 for Hispanic women of the same age.

Poverty rates were the highest among minority women living alone. In 1984, nearly three out of every five (56.6 percent) elderly black women living alone had an income below the poverty level.

A strong and healthy Social Security system and an effective Supplemental Security Income program are vital for older Black Americans because these two sources constitute the bulk of their income. Most older Americans have income from assets - such as interest from savings accounts and dividends from stocks; but not older blacks. Elderly whites are three to four times more likely to have income from assets than aged blacks. Approximately 63 percent of white males 65 or older and 40 percent of elderly white women receive asset income - in contrast to 16 percent for black aged males and 12 percent for black older women.

Social Security benefits are, on the average, lower for blacks than for whites - ranging from 74 to 88 percent of the amounts payable to whites. Social Security has helped to compensate for some disadvantages that blacks have encountered during their working years. However, the greatest problems affecting blacks - lower earnings and higher unemployment during their working years - are still beyond the control of a wage-related program.

RECOMMENDATIONS:

- Elderly populations as a whole, and, particularly minorities, need to be considered as viable participants in state economic development plans and programs.
- Promote and enhance the National Caucus and Center on Black Aged Employment Demonstration Project.
- Network Title V employers into state organizations stressing campaigns to hire older workers.
- Expand income maintenance programs such as SSI, Medicare and Medicaid to cover total health cost of minority poor.
- Historical Black Colleges and Universities need an expanded role in Older Americans Act research and demonstration projects dealing with work roles, capital accumulation and economic well being issues among minority elderly.

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Senator MATSUNAGA. And now we will hear from Ms. Lacayo.

Ms. LACAYO. Thank you very much, Senator Matsunaga. The National Association for Hispanic Elderly truly appreciates this opportunity you and Senator Cochran have given us once again to testify. It has been a long time since we last came before these very respected committees to put forth our concerns and issues.

We will focus on issues with respect to a Hispanic perspective regarding the Older Americans Act and the reauthorization of this Act. One of the first points we want to make as emphatically as possible is that elderly Hispanics and other older minorities are underserved in the Older Americans Act supportive services and nutrition programs. The situation is worsening rather than improving despite a clarion call for action in the 1982 Civil Rights Commission report.

During this decade, the older Hispanic participation rate in OAA programs declined by about one-fifth, from 4.8 percent participation in 1980 to 3.8 percent in 1985. In fact, the elderly Hispanic and aged minority participation rates represent an all-time low for this decade.

A similar pattern exists for the elderly nutrition programs. Aged Hispanics continue to have a low participation rate. They represent just 3.8 percent of those receiving congregate and home-delivered meals. During the past 2 years, the aged Hispanic rate has dropped precipitously by 30.9 percent, from a 5.5 percent participation rate in fiscal year 1983 to 3.8 percent in 1985.

We must be very candid and admit that a serious problem exists. It will not miraculously vanish by statistical manipulation. The National Association is not going to engage in fingerpointing exercises. We simply want to emphasize for the hearing record that aged Hispanics and other elderly minorities are undeserved, especially when measured against their need for services.

The 1984 Older Americans Act included several provisions to promote minority participation in Older Americans Act service programs. One important measure clarified that low income aged minorities were a priority group for receiving supportive and nutrition services.

The National Association believes that this language should be strengthened to stress that low income older minorities should be served on the basis of their need for services. If this provision is appropriately monitored and implemented, it can have a major impact for improving minority participation in Older Americans Act programs.

We strongly believe the Title III supportive and nutrition services programs can benefit from the lessons of the Title V Senior Community Service Employment Program. Title V has done an excellent job in responding to the needs of aged Hispanics and other minorities. One key reason is that the Senior Community Service Employment Program has specific language promoting the recruitment of aged minorities, and it is means-tested, a nasty word in the aging community.

The net impact is that minority participation rates for the Senior Community Service Employment Program are twice as great as for Title III supportive and nutrition programs.

The aged Hispanic participation rate for Title V is almost more than twice as great as it is for Title III, 8.4 percent versus 3.8 percent.

We want to address the question of equitable representation on advisory units. Local decisions concerning types of services and groups served under an area plan are influenced to varying degrees by advisory units such as an advisory council on aging. Aged Hispanics and other minorities, however, are often under-represented or perhaps not represented at all on these advisory bodies.

The National Association believes that it is crucial that we have mandatory language that requires minority representation on these advisory units. The 1982 Civil Rights Commission report found that several factors contributed to the under-representation of aged minorities in Title III programs. Minority aged persons, for example, often felt that Older Americans Act programs were not responsive to their needs and priorities. Nutrition sites frequently did not provide culturally appropriate meals. Few publications were available in languages other than English. Publicity about service programs tended to be limited, especially in languages other than English.

Moreover, outreach efforts were limited. The Commission report said, "The existence of limited outreach programs together with programs unresponsive to minority elderly needs has resulted in low minority participation in almost all cities."

We urge that the 1988 Older Americans Act Amendments include further statutory provisions to improve the administration of existing programs to promote greater minority participation. Specifically, we urge that the reauthorization bill call for area agencies on aging to conduct more vigorous outreach efforts to locate and serve older minorities.

Let me close by saying that we believe that the Older Americans Act should be fine-tuned with respect to the reauthorization. The limited resources under the Act should be targeted, but targeted with very strong statutory language. At this point, the goodwill and good faith of the network simply has not worked. And I am amazed that the Administration on Aging has all of a sudden discovered new statistics that contradict the very same statistics that they gave us in 1986 stating that there was a tremendous decline and a great concern about minority participation.

Senator, we welcome any questions. We heartily support your interest in our issues, and because we have no other recourse except this Committee, we beg you to demand that the aging network be responsive to those older persons with the greatest social and economic need; namely, our people. Thank you, sir.

Senator MATSUNAGA. Thank you, Ms. Lacayo.

[The prepared statement of Ms. Lacayo, with an attachment, follows:]

CARMELA G. LACAYO
President/CEO
JUDGE NELSON A. DIAZ
Chairperson of the Board

ASOCIACION NACIONAL PR[illegible]ERSONAS MAYORES

REGIONAL CENTERS: Los Angeles, CA San Diego, CA Washington, D.C. Miami, FL Chicago, IL New Orleans, LA Detroit, MI Philadelphia, PA

TESTIMONY BY

CARMELA G.LACAYO
EXECUTIVE DIRECTOR

ASOCIACION NACIONAL PRO PERSONAS MAYORES
(NATIONAL ASSOCIATION FOR THE HISPANIC ELDERLY)

BEFORE THE

SUBCOMMITTEE ON AGING
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON

OLDER AMERICANS ACT REAUTHORIZATION
ISSUES AFFECTING OLDER MINORITIES

APRIL 23, 1987

National Association For Hispanic Elderly
National Executive Offices: 2727 West Sixth Street, Suite 270, Los Angeles, CA 90057 (213) 487-1922

Senator Matsunaga and Members of the Subcommittee on Aging, the Asociacion Nacional Pro Personas Mayores (National Association for Hispanic Elderly) appreciates the opportunity to testify this afternoon on the reauthorization of Older Americans Act. At the outset, we wish to commend you for holding this hearing on issues affecting older minorities under the Older Americans Act.

As the major national organization representing the interests of older Hispanics, our testimony will focus on these issues basically from a Hispanic perspective. However, our findings and recommendations apply in many cases to other minority groups as well.

A. Minorities Underserved in Older Americans Act Programs

One of the first points that we want to make as emphatically as possible is that elderly Hispanics and other older minorities are underserved in the Older Americans Act Supportive Services and Nutrition programs. The situation is worsening, rather than improving -- despite a clarion call for action in the 1982 Civil Rights Commission report.

During this decade the older Hispanic participation rate declined by about one-fifth (20.8 percent), from a 4.8 percent participation rate in 1980 to 3.8 percent in 1985. In fact, the elderly Hispanic and aged minority participation rates represent an all time low for this decade.

A similar pattern exists for the Elderly Nutrition program. Aged Hispanics continue to have a low participation rate; they represent just 3.8 percent of those receiving congregate and home-delivered meals. During the past two years, the aged Hispanic participation rate has dropped precipitously by 30.9 percent, from a 5.5-percent participation rate in fiscal year 1983 to 3.8 percent in 1985.

We must be candid and admit that a serious problem exists. It will not miraculously vanish by statistical legerdemain tactics. This is not a problem that can be swept under the rug.

The Asociacion is not going to engage in finger pointing exercises. We simply want to emphasize for the hearing record that aged Hispanics and other elderly minorities are underserved, especially when measured against their need for services.

B. Serve Older Minorities According to Need for Services

The 1984 Older Americans Act included several provisions to promote minority participation in Older Americans Act services programs. One important measure clarified that low-income aged minorities were a priority group for receiving supportive and nutrition services. The Asociacion believes that this language should be strengthened to stress that low-income older minorities should be served on the basis of their need for services. If this provision is appropriately monitored and implemented, it can have a major impact for improving minority participation in Older Americans Act programs.

The Asociacion strongly believes that the Title III Supportive and Nutrition Services program can benefit from the lessons of the Title V Senior Community Service Employment Program (SCSEP). Title V has basically done an excellent job in responding to the needs of aged Hispanics and other minorities. One key reason is that the SCSEP has specific language promoting the recruitment of aged minorities. The net impact is that minority participation rates for the SCSEP are twice as great as for Title III Supportive and Nutrition Services programs.

Comparison of Minority Participation in the Title V SCSEP and the Title III Supportive and Nutrition Services Programs

	Fiscal Year 1985
Title III-B Supportive Services	16.5%
Title III-C Nutrition Program for the Elderly	16.4
Title V SCSEP (National Sponsors)	35.0

Sources: U.S. Department of Labor
Administration on Aging U.S. Department of Health and Human Services.

The aged Hispanic participation rate for Title V is also more than twice as great as for Title III: 8.4 percent vs. 3.8 percent. If Title V can achieve this level of participation, the Asociacion believes that a similar record can be attained for Title III Supportive and Nutrition Services. Strong statutory language stating affirmatively that older minorities should be served according to their need for services would be an important step forward toward implementing this goal.

C. Equitable Representation of Minorities on Advisory Units

Local decisions concerning types of services and groups served under an area plan are influenced, with varying degrees, by advisory units, such as an advisory council or board. Aged Hispanics, however, and other elderly minorities are often underrepresented -- or perhaps not represented at all -- on these advisory bodies.

The Asociacion believes that it is crucial to have minority representation on these advisory units. Their actions quite often determine how effectively aged minorities are served. Minority representation will provide greater assurance that the interests of aged Hispanics and other elderly minorities are appropriately considered.

For these reasons, the Asociacion urges that the 1987 Older Americans Act Amendments include statutory language calling for equitable representation of minorities on state and area agency on aging advisory units.

D. Administrative Actions

The 1982 Civil Rights Commission report found that several factors contributed to the underrepresentation of aged minorities in Title III programs. Minority aged persons, for example, often felt that Older Americans Act programs were not responsive to their needs and priorities. Nutrition sites frequently did not provide culturally appropriate meals. Few publications were available in languages other than English. Publicity about services programs tended to be limited, especially in languages other than English. Moreover, outreach efforts were limited. The Commission report said, "The existence of limited outreach programs together with programs unresponsive to minority elderly needs has resulted in low minority participation in almost all cities."

The Asociacion urges that the 1987 Older Americans Act Amendments include further statutory provisions to improve the administration of existing programs to promote greater minority participation. Specifically, we urge that the reauthorization bill call for the following actions:

- Area agencies on aging should conduct more vigorous outreach efforts to locate and serve aged Hispanics and other low-income older minorities.
- State units and area agencies on aging should work with national aging organizations to alert older minorities about available services under the Older Americans Act.
- More nutrition sites, senior centers and supportive services sites should be located in areas where there are large concentrations of elderly minorities.

E. Promoting Employment, Training and Contract Opportunities

Positive steps are also needed to promote employment, training, and contract opportunities for minorities. This is crucial because minorities have started the race several steps behind Anglos in becoming involved in the field of aging. Now, "catch-up" measures are needed to provide equal access for those wanting to work in the field of aging or to serve older Americans, especially for managerial, professional or administrative positions. For example, Hispanics accounted for only 4.2 percent of all professionals at state offices on aging in fiscal year 1985.

The Asociacion urges that there be appropriate goals and timetables established for the Administration on Aging to promote employment, training, and contract opportunities for minorities in the field of aging. An Office of Civil Rights, or some other appropriate designated unit, should be established within AoA to monitor the implementation of these goals and timetable.

F. Title IV Training, Research, and Demonstrations

Changes are also needed for Title IV Training, Research, and Demonstrations. Title IV has produced many innovative developments which can be replicated nationwide.

The Asociacion recommends that the section 425 national impact program be amended to emphasize that improving the delivery of services for older minorities is a priority for funding. The Asociacion believes that this measure can forge a stronger partnership for national minority aging organizations to work with state units and area agencies on aging to sensitize their personnel about the needs of older minorities and the most effective means to respond to those needs.

The Asociacion further urges that the Cranston amendment be restored. This measure would authorize funding to assess future national personnel requirements, with special emphasis on responding to the needs of the minority elderly. Moreover, it would promote training to prepare minorities for careers in the field of gerontology.

G. Title V Senior Community Service Employment Program

The Title V SCSEP has had a commendable record in serving older minorities. A key reason is that one of Title V's primary goals, since its inception, is to assist the low-income and hard-to-place elderly. Many aged minorities are included in these categories. Congressional sponsors created the SCSEP primarily to aid older Americans who were not in the mainstream in terms of employment skills, education, and economic status. Title V has been extraordinarily effective in providing a dignified way for disadvantaged older Americans to help themselves while helping others in their communities at the same time.

No other program has worked as successfully for downtrodden older workers as the SCSEP. In the opinion of the Asociacion, no other employment or training program has achieved as much as Title V for the amount of money expended.

The Asociacion reaffirms that the SCSEP should continue to emphasize that low-income and hard-to-place older Americans are primary targets for the program. One positive way to clarify this important point is to insert language in section 502, stating that the SCSEP is designed to serve unemployed low-income persons 55 years of older "who have poor employment prospects." This clause would make clear that the most disadvantaged persons in our society are the key target group for Title V.

H. Conclusion

In conclusion, the Asociacion wishes to commend the Subcommittee for holding this hearing on issues impacting on older minorities. This development provides a clear signal of your interest in this subject, and we certainly are delighted.

We also want to emphasize that the Asociacion is ready, willing, and able to work with the Subcommittee on Aging and your staff help assure that older minorities are served more equitably under the Older Americans Act. Our blueprint for action, we believe, is a sound and sensible approach to achieve this objective.

Consequently, we urge the Subcommittee on Aging to incorporate these recommendations in your 1987 Older Americans Act Amendments. Thank you again for inviting the Asociacion to testify. We shall be glad to respond to any questions that you wish to raise.

CARMELA G. LACAYO
President/CEO
JUDGE NELSON A. DIAZ
Chairperson of the Board

ASOCIACION NACIONAL PR[illegible]ERSONAS MAYORES

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ASOCIACION NACIONAL PRO PERSONAS MAYORES

COMPREHENSIVE STATEMENT

ON THE REAUTHORIZATION OF THE OLDER AMERICAN ACT

SUBMITTED BY
CARMELA G. LACAYO
PRESIDENT
ASOCIACION NACIONAL
PRO PERSONAS MAYORES

SEPTEMBER 16, 1986

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The Asociacion Nacional Pro Personas Mayores welcomes the opportunity to submit this statement on the reauthorization of the Older Americans Act. At the outset, the Asociacion wishes to express its support for the Older Americans Act.

During the past two decades, the Older Americans Act has helped to deliver numerous services for aged Hispanics and other elderly persons. In a very real sense, the services under the Older Americans Act have produced a "win-win" situation -- for the elderly and their families, as well as our nation. Homemaker, home health, meals on wheels, and other services have enabled more aged persons to continue to live independently in their own homes. Our nation has also benefited because the Older Americans Act has helped to prevent nursing home and other institutional costs from escalating further.

However, the Act clearly needs to be improved in responding to the needs of aged Hispanics and other low-income older Americans. This, in the judgment of the Asociacion, is the dominant issue for the 1987 reauthorization of the Older Americans Act.

Before focusing on this issue, the Asociacion wants to discuss briefly key demographic characteristics of aged Hispanics. This background information is important for understanding the relationship between the Asociacion's proposals and the state of aged Hispanics in the United States.

Most major elderly minority groups experience a form of double jeopardy because of their low-income and minority status. Aged Hispanics, though, often have an added burden: language. This intensifies other problems such as income, health, and housing. Moreover, limited English-speaking ability can discourage older Hispanics from seeking available benefits.

Education: The formidable language barrier is further compounded by an extraordinarily low level of educational attainment for older Hispanics. In fact, aged Hispanics represent one of the most educationally deprived groups in our society today, especially older Mexican-Americans.

Almost two out of every five (39.4 percent) Hispanics 65 years or older were either illiterate or functionally illiterate in 1982 -- they had completed less than five years of schooling. Nearly five out of eight (62.1 percent) older Hispanics had less than eight years of schooling. And, about three out of four (74.1 percent) had less than nine years of schooling. Only one out of every twenty (5.6 percent) older Hispanics had completed one or more years of college.

The situation is even worse for older Mexican-Americans, the largest Hispanic group by far in the United States. Almost three out of five (56.7 percent) Mexican-Americans 65 or older were either illiterate or functionally illiterate in 1982. Nearly four out of five (79.2 percent) had less than an eighth grade education, and six out of seven (86.3 percent) had never attended high school. Only about one of sixty (1.7 percent) had completed any college level training at all.

Years of Schooling Completed by Hispanics 65 Years of Age or Older, March 1982

	Elementary School			High School		College	
Both Sexes	1-4 Years	5-7 Years	8 Years	9-11 Years	12 Years	1-3 Years	4 Years or More
Hispanic	39.4%	22.7%	12.0%	7.6%	12.6%	2.4%	3.2%
Mexican Origin	56.7	22.5%	7.1	6.0	6.0	1.0	0.7
Other Hispanic Origin	16.9	23.2	18.3	9.3	21.5	4.4	6.4

Note: Figures may not total because of rounding.

Source: "Persons of Spanish Origin in the United States: March 1982," Current Population Reports, Series P-20, No. 396, United States Dept. of Commerce, Bureau of the Census, Issued Jan. 1985, p. 16.

Income: Income levels continue to be extremely low for aged Hispanics. In 1981, the median annual income was just $5,257 (approximately $101) a week for an Hispanic male 65 years or older and only $3,496 (about $67 a week) for an aged Hispanic female. Older Mexican-Americans had a similarly low median annual income: $5,433 (approximately $104 a week) for an aged male and $3,310 (about $64 a week) for an elderly female.

Nearly one out of every two (47.0 percent) Hispanic males 65 years or older and three out of four elderly Hispanic females (74.7 percent) had annual incomes below $5,000. About three out of seven (43.5 percent) aged Mexican-American males and three out of four (77.4 percent) older Mexican-American females lived on less than $5,000 a year.

Only one out of twenty (5.2 percent) aged Hispanic females and one out of a hundred (0.9 percent) elderly Mexican-American women had annual incomes of $10,000 or more.

Income in 1981 of Hispanic Persons 65 Years of Age or Older

	Hispanic		Mexican Origin	
Income Bracket	Male	Female	Male	Female
Median	$5,257	$3,496	$5,433	$3,310
$ 1 - $1,999	4.6%	14.0%	4.7%	20.4%
$ 2,000 - $2,999	10.7	24.5	8.6	24.5
$ 3,000 - $3,999	15.7	23.2	16.0	16.3
$ 4,000 - $4,999	16.0	13.0	14.2	16.2
$ 5,000 - $5,999	11.9	11.7	14.9	13.7
$ 6,000 - $6,999	8.5	4.1	7.7	3.9
$ 7,000 - $9,999	15.8	4.4	15.6	4.0
$10,000 - $14,999	8.8	3.7	9.9	0.9
$15,000 - $19,999	3.4	0.3	3.5	-
$20,000 - $24,999	2.5	1.2	3.3	-
$25,000 and over	2.2	-	1.7	-

Note: Figures may not total because of rounding.

Source: "Persons of Spanish Origin in the United States: March 1982," Current Population Reports, Series P-20, No. 396, United States Dept. of Commerce, Bureau of the Census, Issued Jan. 1985, p. 27.

Poverty: Aged Hispanics are more than twice as likely to be poor as elderly Anglos. In 1985, 23.9 percent of all Hispanics 65 years or older lived in poverty, compared to 11.0 percent for all elderly Whites.

Poverty is a bare-bones existence, according to the U.S. Census Bureau definition. An individual 65 or older was considered poor in 1985 if his or her income was below $5,156. This translates into $99 per week to pay for housing, food, medical care, transportation, clothing, and other everyday necessities. An aged couple was poor if their income fell below $6,503 a year ($125 a week).

The number of elderly Hispanics living in poverty increased by 43,000 last year, from 176,000 in 1984 to 219,000 in 1985. This represented the highest number of impoverished aged Hispanics, since poverty statistics were first tabulated for the elderly Spanish-origin population. The percentage of aged poor Hispanics, also rose, from 21.5 percent in 1984 to 23.9 percent, in 1985.

To a very large degree, elderly Hispanics have been treading water for years in the economic rapids that threaten to engulf them. For all practical purposes there has been virtually no change in the poverty rate for older Hispanics during the past twelve years: 24.9 percent in 1973 compared to 23.9 percent in 1985.

In addition to the 219,000 older Hispanics living in poverty, another 100,000 are marginally poor. Their incomes are within 25 percent of the poverty lines. The net impact is that 319,000 aged Hispanics -- one out of every three (34.8 percent) Hispanics 65 or older -- either live in poverty or so close to it that it is virtually impossible to tell the difference.

In aged Hispanic households with a female householder and no husband present, 50.4 percent of all the members were poor in 1985.

These figures probably understate the dimensions of the problem because of the undercounting of older Hispanics. Persons who are missed in the Census tabulations usually have a greater likelihood of being poor or near poor.

Poverty Levels and Rates for Aged (65 or Older) Hispanic Persons and Other Older Americans: 1985 (Numbers in Thousands)

	All Older Americans	Whites	Hispanics
Number Poor	3,456	2,698	219
Percent Poor	12.6%	11.0%	23.9%

Source: "Money Income and Poverty Status of Families and Persons in the United States: 1985 (Advance Data From The March 1986 Current Population Survey)," Current Population Reports, Consumer Income, Series P-60, No. 154, Issued Aug. 1986, p. 22.

Aged Persons (65 or Older)
Below 125 Percent of the Poverty Levels: 1980
(Numbers in Thousands)

	All Older Americans	Whites	Hispanics
Number Poor and Near Poor	5,706	4,621	319
Percent Poor and Near Poor	20.9%	18.8%	34.8%

Source: "Money Income and Poverty Status of Families and Persons in the United States: 1985 (Advance Data From the March 1986 Current Population Survey)", Current Population Reports, Consumer Income, Series P-60, No. 154, Issued Aug. 1986, p. 25.

Serving Older Minorities More Equitably

Older minorities have a need for services that is typically two to three and one-half times as great as for the non-minority aged. However, the 1982 Civil Rights Commission report and earlier equity studies for the Administration on Aging (AoA) have generally concluded that elderly minorities have been underserved by the older Americans Act, especially when need for services is considered.

Moreover, the situation has deteriorated further. In fact, the minority participation rate for the Older Americans Act Title III-B Supportives Services Program has dropped by 24.7 percent during this decade, from 21.9 percent in fiscal year 1980 to 16.5 percent in 1985. Older Hispanics have had a 20.8-percent reduction, from a 4.8 percent participation rate in 1980 to 3.8 percent in 1985. The older Hispanic and aged minority participation rates represent an all-time low for this decade. The elderly minority participation rate for the Title III-C Elderly Nutrition Program has declined by 13.7 percent during this decade, from a high of 19.0 percent in fiscal year 1980 to a low of 16.4 percent in 1985. Aged Hispanics continue to have a low participation rate -- only 3.8 percent of all those receiving congregate and home-delivered meals. During the past two years, the aged Hispanic participation rate has plummeted by 30.9 percent, from a 5.5 percent participation rate in fiscal year 1983 to 3.8 percent in 1985.

Minority Participation in Title III Supportive and Nutrition Services

Fiscal Year	Supportive Services			Nutrition Services		
	Total	Minorities	Percent Minorities	Total	Minorities	Percent Minorities
1980	9,336,993	2,047,007	21.9%	3,083,454	585,584	19.%
1981	8,885,747	1,607,229	18.1	3,400,952	644,203	18.9
1982	9,160,079	1,653,980	18.1	3,355,778	603,996	18.0
1983	9,171,609	1,625,390	17.7	3,759,222	705,258	18.8
1984	9,126,122	1,597,589	17.5	3,530,288	610,052	17.3
1985	9,331,154	1,535,112	16.6	3,630,117	595,619	16.4

Note: 1980 figures refer to participation for approved area plans.

Source: Administration on Aging, U.S. Dept. of Health and Human Services.

Hispanic Participation in Title III Supportive and Nutrition Services

Fiscal Year	Supportive Services		Nutrition Services	
	Hispanics	Percent Hispanics	Hispanics	Percent Hispanics
1980	444,804	4.8%	121,436	3.9%
1981	350,390	3.9	166,276	4.9
1982	363,007	4.0	149,140	4.4
1983	353,479	3.9	205,794	5.5
1984	371,230	4.1	144,248	4.1
1985	357,752	3.8	139,352	3.8

Note: 1980 figures refer to participation for approved area plans.

Source: Administration on Aging, U.S. Dept. of Health and Human Services.

__Serving Minorities According to Need for Services:__ The 1984 Older Americans Act included several provisions to promote minority participation in Older Americans Act services programs. One important measure clarified that low-income aged minorities were a priority group for receiving supportive and nutrition services. The Asociacion believes that this language should be strengthened to emphasize that low-income older minorities should be served on the basis of their need for services. If this provision is appropriately monitored and implemented, it can have a major impact in boosting minority participation in Older Americans Act programs.

The Title V Senior Community Service Employment Program (SCSEP) has specific language promoting the recruitment of aged minorities. Moreover, the Department of Labor has entered into contracts with three national minority aging organizations -- the Asociacion, the National Caucus and Center on Black Aged, and the National Urban League -- to increase the number of minority enrollees in Title V projects. These actions have helped to produce minority participation rates for the SCSEP which are twice as great as for the Older Americans Act Title III Supportive and Nutrition Services Programs.

Comparisions of Minority Participation in the Title III SCSEP and the Title III Supportive and Nutrition Services Programs

	Fiscal Year 1984	Fiscal Year 1985
Title III-B Supportive Services	17.5%	16.5%
Title III-C Nutrition Program for the Elderly	17.3	16.4
Title V SCSEP (National Sponsors)	34.2	35.0

Sources: U.S. Dept. of Labor

Administration on Aging, U.S. Dept. of Health and Human Services

The aged Hispanic participation rate for Title V is also more than twice as great as for Title III: 8.4 percent vs. 3.8 percent. If this level of participation can be achieved for the SCSEP, the Association believes that it can be attained for Title III Supportive and Nutrition Services.

Administrative Actions: The 1982 Civil Rights Commission report found that several factors contibuted to the underrepresentation of aged minorities in the Title III services programs. Minority aged persons, for example, often felt that Older Americans Act programs were not responsive to their needs and priorities. Nutrition sites frequently did not provide culturally appropriate meals. Few publications were available in languages other than English. Publicity about services programs tended to be limited, especially in languages other than English.

Moreover, the Civil Rights Commission found that the aging network did not generally conduct aggressive outreach efforts to locate more minority elderly persons. The Commission staff pointed out: "The existence of limited outreach programs, together with programs unresponsive to minority elderly needs, has resulted in low minority participation in almost all cities.[8]

The report further noted that the aging network had not been diligent in monitoring participation by the minority aged. Minorities were underrepresented in the planning process for the delivery of services, such as advisory councils. And, nutrition sites and senior centers were frequently located in areas in the community which were not accessible to older minorities.

The Asociacion urges that the 1987 Older Americans Act Amendments include specific statutory language to emphasize the following:

o State and area agencies on aging should take affirmative steps to insure greater minority participation on advisory councils and other similar units.

o More nutrition sites, senior centers, and supportive services sites should be located in areas where there are large concentrations of elderly minorities.

o Area agencies on aging should conduct more vigorous outreach efforts to locate aged Hispanics and other older minorities.

o Older minorities should be targeted for services in proportion to their need.

Affirmative Actions: Affirmative action is also needed to promote jobs, training, and contract opportunities for minorities. Minorities have started the race several steps behind Anglos in becoming involved in the field of aging. Now, "catch-up" measures are needed to provide equal access for those wanting to work in the field of aging or to serve older Americans. This is particularly true for professional or managerial positions. For example, Hispanics accounted for only 4.2 percent of all professionals at state offices on aging in fiscal year 1985.

The Asociacion urges that there be appropriate goals and timetables for affirmative action for the Administration on Aging, state offices on aging, and area agencies on aging to promote employment, training, and contract opportunities for minorities in the field of aging. An Office of Civil Rights, or some other appropriate designated unit, should be established within AoA to monitor the affirmative action goals and timetables.

Reinstatement of Cranston Amendment: The Cranston Amendment should be restored for Title IV Training, Research, and Special Projects. This measure would authorize funding to assess future national personnel requirements, with special emphasis on responding to the needs of the minority elderly. Moreover, it would promote training to prepare minorities for careers in the field of gerontology.

Opposition to Redirecting Scarce Resources to Other Groups: The Asociacion has identified several positive measures to promote minority participation in all Older Americans Act activities. It is also important to be vigilant for measures which may impede minority participation in Older Americans Act programs.

Specially, the Asociacion is concerned about proposals to redirect more of the Older Americans Act resources to the so-called vulnerable elderly by:

- Allocating Title III funds according to the 70-plus population, rather than 60 or older as under present law.
- Emphasizing that vulnerable older individuals are to be targeted under the definition of "greatest social need."

Additionally, the Asociacion is concerned about an emphasis on promoting community-based services if this means costly health-related services under the Older Americans Act.

The Asociacion believes that the Older Americans Act can respond to certain needs of vulnerable older Americans. However, there are other programs, which are more appropriate and are already in place, to assist the vulnerable elderly. These include Medicaid and Medicare in the health arena. Other programs exist for other needs of the vulnerable elderly, such as the Social Services Block Grant and congregate housing services programs older Americans who are risk of being institutionalized.

We do not believe that it is wise to dilute the Older Americans Act's already scarce resources to focus more attention on the vulnerable elderly, especially when the Act is responding inadequately to the needs of the minority aged. During the past five years, the minority participation in Title III-B Supportive Services has declined by 512,000, from 2.047 million in fiscal year 1980 to 1.535 million in 1985. The number of aged Hispanics served by Title III-B has dropped by 87,000, from 445,000 in fiscal year 1980 to 358,000 in 1985.

Moreover, services for the vulnerable elderly -- particularly if they are health related -- will probably cost more and limit existing resources for current Older Americans Act clients. For these reasons, the Asociacion reaffirms that more efforts should be directed to reaching low-income minorities because they have the greatest need for services.

Long-Term Extension of the Older Americans Act

The Asociacion favors a long-term extension of the Older Americans Act. We believe that all programs should be extended at least three years, and preferably five years.

A long-term extension will provide greater continuity for Older Americans Act programs. It will also enable program administrators to plan their operations with adequate lead time.

Moreover, the Asociacion favors perfecting changes for the Act. In general, we believe that the Older Americans Act is well conceived. We do not favor a fundamental restructuring of existing programs. Our emphasis would be upon fine tuning changes to update the law because of new developments.

Increased Authorizations

Authorized funding levels should be adjusted for inflation and expected growth in the aging population. Today, a great need exists for Older Americans Act services under Title III and employment opportunities under the Title V SCSEP. However, the Older Americans Act is reaching only a relatively small proportion of eligible persons, particularly the SCSEP. The Asociacion urges that larger authorization increases be directed to the SCSEP to permit more low-income older Americans to help themselves by helping others in their communities at the same time. This proposal would be especially beneficial for aged minorities because Title V has been one of the most effective and responsive programs for aged Hispanics and other low-income older Americans.

Separate Authorizations for Supportive and Nutrition Services

The Asociacion supports the continuation of separate authorizations for supportive services, congregate meals and home-delivered meals under Title III. We are concerned that any attempt to consolidate Title III programs can open the door for block-granting the Older Americans Act.

The Asociacion believes that this would be a serious mistake because aging issues require national attention since they are national in scope. A federal commitment in the field of aging is absolutely essential today, as it was when the Older Americans Act was enacted in 1965. The need may be even greater now because our nation is rapidly becoming older. The graying of our population will accelerate in the years ahead, particularly during the first quarter of the twenty-first century.

Retention of Priority Services

We also support retention of the three priority services under Title III: access, in-home, and legal. All three are high priority services which area agencies on aging should fund as a matter of course. However, political pressures are often applied to local offices on aging to discourage the funding of legal services projects. As a consequence, many area agencies on aging provide only token amounts for legal services, and in some cases nothing at all.

Yet, legal assistance is an especially high priority need for aged Hispanics and other low-income minorities. Unfortunately, large numbers are now forced to fend for themselves when a legal problem arises -- whether it involves litigation, understanding the technicalities of federal programs or planning their personal affairs.

The Asociacion urges that the priority services language be strengthened to establish a minimum floor for legal services to guarantee an adequate amount of funding to assure that older Americans are more appropriately represented.

Title IV Training, Research, and Demonstrations

The Asociacion urges that Title IV Training, Research, and Special Projects be basically continued in its present form. The 1984 Older Americans Act Amendments made several positive changes for Title IV, including providing more direction for training, research and demonstration activities; strengthening Title IV reporting requirements; and placing restrictions on mixing Title IV appropriations with funding from other programs.
We believe that several existing Title IV provisions should be retained, including:

- The preference for funding demonstration projects which respond to the needs of low-income, minority and limited English-speaking individuals.

- National impact projects which show promise of having a substantial effect on expanding or improving services for the elderly, or otherwise promoting their well-being.

- National legal services demonstration programs to expand or improve the delivery of legal assistance to older Americans with social or economic needs.

The Asociacion is concerned about proposals to permit for-profit corporations to receive Title IV grants for research, demonstrations, multidisciplinary centers of gerontology, special projects in comprehensive long-term care, and legal assistance demonstrations. Supporters claim that this will promote competition.

This measure, though, may have the effect of attracting businesses and industries that are only concerned with making a profit, rather than providing a long-term commitment to the field of aging. Many activities and undertakings in gerontology do not lend themselves to profitable returns in terms of dollars and cents. Yet, these endeavors -- such as the development of data bases and others -- are crucial for the evolvement of gerontology in our society. Research and the acquisition of information may not always be immediately practical and profitable in a business sense. However, there may be compelling arguments for pursuing these undertakings.

The Asociacion urge caution before allowing potentially profiteering businesses to obtain Title IV funds when they may lack necessary knowledge and commitment to the field of aging. We, therefore, urge that these proposals be rejected.

Senior Community Service Employment Program

The Title V Senior Community Service Employment Program (SCSEP) has been an extraordinarily successful program by any standard one would choose to use. We consider the SCSEP to be the most successful employment program ever developed. Title V has functioned effectively and efficiently throughout its existence. It should be extended with increased authorizations and essentially fine-tuning changes.

The Asociacion has two recommendations for the SCSEP. First, the administrative cap should be restored to 15 percent. The 1984 older Americans Act Amendments reduced the administrative cost ceiling by 20 percent in two stages -- from 15 percent to 13.5 percent on July 1, 1986 and then to 12 percent on July 1, 1987. Unfortunately, this provision will inevitably cause some Title V enrollees to lose their jobs because sponsors must eventually close existing sites in order to consolidate their operations to conform to the lower administrative ceiling.

Moreover, it will quite likely discourage sponsors from promoting unsubsidized placements because this activity can increase their administrative costs. There may be some evidence that this has aready occurred. Unsubsidized placements dropped for both national sponsors and states during the past program year -- from 22.0 percent during the 1984-85 program year to 21.9 percent for 1985-86 for national sponsors and from 17.7 percent to 17.3 percent for states. This slight decline may reflect preparatory actions taken by national sponsors and states to prepare for the new lower ceiling. If unsubsidized placements fall, then the number of low-income older persons participating in Title V will decline.

The lower cap will also quite likely pose problems for the equitable distribution of enrollees throughout a state. This will probably give the program more of an urban bias, although the poverty rate is higher among the rural aged than the urban elderly.

Second, the Asociacion urges that the $5,111 average cost per enrollee be adjusted to reflect rising operating costs, such as worker's compensation, telephone, rent, rising state minimum wages and others. The current average has remained in effect for five years.

Both the House and Senate have included report language for the Fiscal Year 1987 Labor-Health and Human Services-Education Appropriations Act, calling upon the Department of Labor to submit a report on this issue by February 15, 1987. This report should provide useful information to make appropriate adjustments in the average cost per enrollee.

Conclusion

In conclusion, the Asociacion reaffirms its support for the Older Americans Act. We strongly believe that this legislation has benefited senior citizens, local communities and our nation. It can, of course, be perfected. The Asociacion's proposals can help to strenghten the Older American Act. For these reasons, we urge that they be adopted when the Congress considers the reauthorization legislation.

Senator **Matsunaga**. Ms. Kamikawa.

Ms. **Kamikawa**. Thank you, Senator Matsunaga, Senator Cochran, for the opportunity to present a perspective from my community and from older Pacific Asian elderly. I think one of the very striking features about our community is its invisibility. Except for the trade deficit, I think by and large the recognition of Pacific Asians is minimal. We are talking about a generic identifier that really comprehensively covers 18 subethnic groups that include native Hawaiians to the recently immigrated Southeast Asians. I think that points out a very crucial issue which is very little known, and that is the poverty threshold for all older Pacific Asians is at a 22 percent level, which surpasses the majority population and is commensurate with other minority groups.

Moreover, within some groups, we have higher percentage. With the Vietnamese, we are talking about a 45 percent population below the threshold of poverty. With the Hawaiians we are talking about a 34 percent population below that mark, and with Samoans we are talking about 38 and even with the Chinese, we are talking about a grouping of older Chinese that comprise 25 percent of that threshold.

I think that that clearly points out the need for identifying the diversity in this country and surely the diversity within our population. I would like to point out, as well, that we are the fastest growing minority population in this country, not the largest, just the fastest growing. Between 1970 and 1980, we grew by 128 percent. We went from 1.5 to 3.5 million individuals in this country. The greatest confronting issue, I think, that is posed to this body as well as any body who is investigating the reauthorization issues for the 1987 authorization is what to do about those populations who are in greatest social and economic need.

We are talking about minority populations who come to their later years already vulnerable. We are not talking about people who become vulnerable because they are older, but who have lived in a country already living in an at risk state and then reaching an older age which are exacerbated by that very age.

Consequently, when we look at the reauthorization, I think it becomes incumbent upon developing a blueprint that will more clearly articulate how to better use the system to make it more effective and more accountable to the diversity in this country which it has heretofore failed to do as exemplified by those statistics given to you earlier.

If we look at minority population on Pacific Asians, in the area of Title III nutrition, we have dropped 24.6 percent in support services, and 17.6 percent in nutrition congregate meal sites. I have no idea how those have gotten reversed since 1986, and have great questions about it. But it does raise the issue with regard to one of the major concerns that our organization has around the management information system. Those of us who clearly have served in any capacity—I who am a mathematician—and those who have done research know very clearly that it is not plausible to ask the delivery system to examine itself and to hold itself accountable. That is not possible. We are talking about human frailty and our inability to look at ourselves objectively.

So it is with our government; is it not? That we talk about a system of checks and balances. We ask that this body look at it from the perspective of how do we account for the reporting system that becomes so vital to those in greatest economic need. Let me give you an anecdote because I think it is so apropos to some of the experiences the national organizations have.

When we have informal discussions, I know that one of the area agency directors said to me, look, Louise, one of the ways that we determine what our participation is—because at the very basic level, those individuals who are accountable for reporting really do not feel that it is part of their job to do that. Consequently, the area agencies can determine what the poverty level is or the numbers are in their catchment area and report that as part of what they should account for. The consequence of that is that we have an inaccurate reporting system. I think that that is one of the very crucial issues. The other issues are, of course, to, in fact, strengthen the statutory language. I think it becomes very important that we not, in fact, dilute it by including too many factors that make it plausible for us to go back to simplistic formula.

I ask you as monitors of our Government that it becomes important that you look at those issues and ensure that the rights and responsibilities of those agencies and individuals getting those services are equitably distributed. Thank you.

Senator MATSUNAGA. Thank you very much, Ms. Kamikawa.

[The prepared statement of Ms. Kamikawa follows:]

NATIONAL PACIFIC/ASIAN RESOURCE CENTER ON AGING

REAUTHORIZATION
OF THE OLDER
AMERICANS ACT
1987

Testimony of
Lōuise M. Kamikawa
Director

Before the Subcommittee on Aging
Senate Committee on Labor and Human Resources

April 23, 1987

Senator Matsunaga and members of the Subcommittee on Aging, I would like to thank you for the opportunity to provide testimony at this hearing.

As my presentation today will be a synopsis of the National Pacific/Asian Resource Center on Aging's longer statement, I will ask that unanimous consent be given to have the entire text printed in the hearing record.

We support your efforts to examine, in greater depth, the major issues impinging on the reauthorization of the Older Americans Act. The primary confronting issue to be addressed is, how can the Older Americans Act be restructured to more effectively and equitably meet the needs of the minority elderly? Our perspective, of course, will primarily focus on the Pacific/Asian elderly population, but by inference support the position of all perspectives provided by other minority groups represented today.

PACIFIC/ASIANS ELDERLY

There are two caveats that one should keep in mind in any discussion of elderly Pacific/Asians. The first pertains to the inherent diversity of population. Elderly Pacific/Asians include native-American Hawaiians and recent Indo-Chinese refugees, first-generation Issei for Japan and third-generation American born Sansei, Samoans sharing the same household with a myriad of extended family members and single Pilipino men living alone in rooming houses, college educated Chinese and illiterate Chinese. Among this broad span of people are the commonly acknowledged variations in language, values, traditions, and history (Pacific/Asian Elderly Research Project, 1987b) and the less frequently cited differences in life expectancy and health (Yuen Schwitters & Ashdown, 1981; Yuen Schwitters & Tomita, 1981). Thus, although individuals of Asian and Pacific Islander backgrounds frequently are lumped into a single category, generalizations regarding the group as a whole are often misleading, for what may be accurate for one subset may not be so for another.

The fact that the Pacific/Asian population is dynamic and constantly changing is the second caveat of which one should be aware. Whereas the heterogeneity of the population refers primarily to within group differences (that is, among the various ethnicities within the Pacific/Asian group), the dynamism of the population results largely from cohort differences over time. Changes in migration patterns, reproduction rates, and acculturation contribute to an ever shifting Pacific/Asian scene. For example, in 1970 the Japanese comprised the largest ethnic group within the Asian and Pacific Islander population in the United States. In 1980, however, primarily because of different levels of immigration, the Chinese counted by census grew from 435,062 to 806,027 individuals, a percentage increase of 85.3%, the Pilipinos increased from 343,060 to 774,640 individuals for an increase of 125.8%, while the Japanese experienced the slowest growth--from 591,290 to 700,747 individuals and an increase of 18.5% (Bureau of the Census, 1981). Of particular interest is the fifth largest group by the 1980 census count, the Koreans (fourth were the Asian Indians with 361,544 individuals), who quadrupled their number by a phenomenal 412.8% between 1970 and 1980 (from 69,130 to 354,529 individuals). Besides the uneven growth among the different ethnic groups, other factors such as the more balanced sex ratio among younger generations of Asians and the regional re-distribution of the Pacific/Asian population (e.g. 13.4% were located in the South in 1980 compared to 7.4% in 1970), make it imperative that the statements and perceptions regarding this minority group are continually reshaped and updated.

Some of our assumptions regarding Pacific/Asian older people may be truisms, others may contain a kernel of truth, and still others may simply be romanticized ideals relating to the past. All of these common assumptions need to be examined in light of the changing Pacific/Asian patterns in demography, social ascendancy, and assimilation with the majority culture.

In 1970 there were 1.5 million Pacific/Asian individuals in the United States. A decade later their numbers had increased to 3.5 million--a growth rate of 128%, higher than that of the majority or of any other minority group in the nation--and the sharp expansion is expected to continue in the years ahead. The total Asian and Pacific Islander population exceeds the size of the population of 28 states of the Union. Older Pacific/Asians are expected to increase at an even faster rate than their younger cohorts, a prediction that is based on the aging of the relatively "young" Pacific/Asian population, their increased life expectancy, and the addition of recent elderly immigrants (sponsored into the United States by children and relatives). The changes wrought by demography and time will result in greater diversity and modifications in the composition of this group. The term Pacific/Asian will be stretched to cover fourth and fifth generation, highly educated individuals who are well assimilated into the majority group, economically secure, and knowledgeable about dealing with the bureaucratic system, as well as recent non-English speaking immigrants with little education and few technical skills, who feel more comfortable living a traditional lifestyle largely within minority enclaves. The preponderance of elderly men in some ethnic groups will disappear, and there will be more elderly women among all Pacific/Asian groups than is true at the present time. The Pilipinos and Indo-Chinese will constitute larger proportions of the total Pacific/Asian population, resulting in corresponding reductions in some of the other ethnic group.

POVERTY STATISTICS FOR OLDER ASIAN AMERICANS AND PACIFIC ISLANDERS

Poverty and Near Poverty Among Asians and Pacific Islanders 65 Years or Older in 1980

All Older Asians or Pacific Islanders	216,382	31,289	14.5%	47,644	22.0%
Japanese	49,382	4,297	8.6	6,790	13.6
Chinese	54,882	9,045	16.5	13,902	25.3
Filipino	55,019	5,621	10.2	8,921	16.2
Korean	8,464	1,360	16.1	2,014	23.8
Asian Indian	30,938	6 026	19.5	9,574	30.9
Vietnamese	4,558	1,641	36.0	2,086	45.8
Hawaiian	9,311	2,392	25.7	3,173	34.1
Guamanian	719	149	20.7	186	25.9
Samoan	771	176	22.8	294	38.1
Other Asian or Pacific Islanders	1,749	582	33.3	704	40.3
All Races	24,454,364	3,581,729	14.6	5,723,766	23.4%
White	21,691,260	2,774,505	12.8	4,618,456	21.3

Source:
Bureau of the Census
763-5790

REAUTHORIZATION OF THE OLDER AMERICAN ACT

One of the more fundamental issues in the reauthorization of the Older Americans Act (OAA) is to assure that aged minority persons are equitably served. The 1983 Civil Rights Commission report plus earlier equity studies funded by the Administration on Aging (AoA) have made three key points:

- Older minorities have a greater need for services than aged whites, typically 2 to 3-1/2 times as great as the non-minority elderly.
- Aged minorities have not been served under the OAA according to their needs.
- Elderly minorities have been inequitably served under the OAA.

These findings have generally been accepted either partially or totally by many persons working in the field of aging. However, our nation seems to be going backwards now, rather than forward, in responding to the needs of older minorities under the OAA. Our perspective, of course, will primarily focus on the Pacific/Asian elderly population.

Legislative Authority

In its deliberations, should Congress initiate any changes in the OAA, there are certain guiding principles which underpin the overall intent of the OAA and its responsiveness to minorities and the Pacific/Asian Elderly.

- The integrity of the thrust to provide services under Title III, continue to be focused on those "in greatest economic or social need".
- The commitment to the Indian tribes, established in the 1978 amendment, in a program of grants be continued.
- The discretionary program as currently prescribed should be maintained. It is essential that AoA be the conduit for pinpointing the necessary research areas, identifying training needs, and developing model projects for replication. Greater emphasis in research and demonstration should be placed on minority populations. Education and training programs are in need of realignment which would systematically utilize existing mechanisms for development.

The legislative intent of the OAA has been to provide an alternative to the systematic problems related to the provision of services by a variety of agencies to older persons. The formidable task in such an endeavor requires adherence to some fundamental precepts. The primary one being that all segments of the older population be provided the opportunity to all services and benefits. In our recommendations, we are attempting to provide a perspective of a population heretofore minimally benefiting from such services. It is our belief that achievement in addressing the concerns and needs of the Pacific/Asian elderly refines the system to work more effectively.

The National Pacific/Asian Resource Center on Aging (NP/ARCA) recommends that Congress extend the authorizations for the OAA for two years.

Minority Participation in the Older Americans Act Title III Program

The latest information from (AoA) make this point all too clear. During the past five years, the aged minority participation rate has fallen by one-fourth (24.7 percent) for the OAA Title III-B supportive services program from 21.9 percent in fiscal year 1980 to 16.5 percent in 1985. Throughout the 1980's the minority participation rate has declined every year with the exception of 1982, when it remained unchanged. In fact, the FY 1985 rate represents an all time low during this decade for elderly minorities.

The nutrition program for the elderly has also experienced a similar decline, alhtough not as steep as for supportive services. The aged minority participation rate has dropped by 13.7 percent during this decade, from a high of 19.0 percent in fiscal year 1980 to a low of 16.5 percent in 1985. Every year, with the exception of 1983, the minority participation rate has fallen.

A similar pattern exists for aged Asian Americans and Pacific Islanders. Their participation rate has consistently declined during this decade. Over-all, the elderly Asian Americans and Pacific Islanders participation rate has dropped by 17.6 percent for both supportive services and elderly nutrition programs, from 1.7 percent in fiscal year 1980 to 1.4 percent in 1985.

Older Asian Americans and Pacific Islanders are near the bottom of the statistical chart for receiving Title III-B supportive services. Only aged Indians and Alaskan Natives have a lower participation rate among major minority groups.

In the case of the home-delivered meals program, older Asian Americans and Pacific Islanders are at the bottom. Less than 1 percent (0.9 percent) of all participants in the meals-on-wheels program are elderly Asian Americans and Pacific Islanders. This compares to 1.6 percent for the congregate meals program. As you know, the home-delivered meals and congregate meals programs comprise the elderly nutrition program.

Consolidation of Title III Program

This formula has been used in the consolidation of many entitlement program in the past seven years, (i.e., Title XX of the Social Security Act, social service block grants) with the rationale that gives more local authority and control. However, experience demonstrates that ultimately there is a reduction in monies for consolidated programs and that the monitoring and evaluation process is underminded.

Under the OAA, it is crucial that the programs not be consolidated. The support services have been vital to the participation of minority individuals. It is generally those with fewer resources and income that require support services and these services are generally the ones that are often eliminated. It is essential that prescriptive language be maintained to protect those most in need. Traditionally, local jurisdications have tended to direct monies into the congregate meals program rather than the support services; such a policy decision at that level has resulted in a program which serves the more affluent, able white population, lessening the job responsibilities of the providers.

The efforts of the national minority organizations and the respective minority communities have met with overwhelming opposition in getting the network to respond to the needs of older minority persons. The elimination of the three separate programs will make it virtually impossible to get local providers to earmark monies for these programs; moreover, there will be no means by which the area agencies on aging (AAA) can be held accountable. This recommendation in concert with the recommendation to repeal Section 306 (a) will serve to exacerbate the inequities of the system. The statistics on minority participation demonstrate the lack of responsiveness of the system; and in the past three years the situation has worsened. To consolidate these programs and to repeal "an adequate proportion of supportive services funds be spent for legal services, in-home services, and access services", would create a "block grant" formula whereby minority senior who are in greatest need will pay the highest price.

Elderly Minorities' Participation Rate In Older Americans Act Title III Programs

	Supportive Services		Nutrition Program		Congreate Meals		Home-Delivered Meals	
Fiscal Year	Minority	API	Minority	API	Minority	API	Minority	API
1980	21.9%	1.7%	19.0%	1.7%	NA	NA	NA	NA
1981	18.1	1.7	18.9	1.4	18.9	1.4	19.2	1.4
1982	18.1	1.7	18.0	1.7	17.6	1.9	20.0	0.9
1983	17.7	1.7	18.3	1.4	18.8	1.5	18.8	0.9
1984	17.5	1.5	17.3	1.4	17.0	1.5	18.7	0.8
1985	16.5	1.4	16.4	1.4	16.2	1.6	17.3	0.9

NA - Not Available

API- Asians and Pacific Islanders

Enforce Provisions Already Enacted Into Law

The National Pacific/Asian Resource Center on Aging supports a three-pronged approach to increase aged minorities' participation in the OAA Title III supportive and nutrition services. First, (AoA) should enforce fully existing provisions to help assure that aged minorities are equitably served.

The 1984 OAA Amendments added a number of key provisions to strengthen minority participation. For example, the 1984 Amendments made clear that low-income older minorities were a priority group for receiving services. Moreover, the law now directs Administration on Aging to consult with national minority organizations in developing training packages and providing technical assistance to help state and local offices on aging deliver services to the elderly with the greatest needs. Finally, the 1984 Amendments provide for minority representation on the Federal Council of the Aging.

All of these measures represented constructive steps to promote minority participation in the Title III supportive and nutrition services programs. However, (AoA) must properly implement these provisions if they are to fulfill congressional intent.

Enactment of New Provisions to Strengthen Minority Participation

National Pacific/Asian Resource Center on Aging believes that the existing standard relating to serving older persons with the "greatest economic or social needs" should be strengthened. Low-income aged minorities should not only be a priority group for receiving Title III supportive and nutrition services, but they should also be served on the basis of their need for services. Additionally, legislative measures should be enacted to promote employment and contract opportunities for minorities in the field of aging. National Pacific/Asian Resource Center on Aging favors strong statutory language to require federal, state and local offices on aging to establish appropriate target goals, with time tables and an action plan, to increase employment, training, grant and contract opportunities for minorities. The recent Civil Rights Commission report documented this need forcefully and persuasively. Appropriate monitoring provisions should be adopted with sanctions for offices on aging which fail to comply.

Finally, language should be incorporated in Title IV to promote career preparation training for all minorities, including Pacific Islanders/Asian Americans. This is crucial to attract more minorities into the field of aging. Currently, there is a dearth of adequately trained minorities in gerontology. This language is also essential to emphasize that career level education for minorities is a high priority under the Older Americans Act.

Opposition to Provisions Diluting Minority Participation

It is necessary that Congress be vigilant regarding provisions--no matter how well intentioned--which can have the effect of diluting minority participation in OAA programs. National Pacific/Asian Resource Center on Aging is deeply concerned about two proposals which are included in a draft Administration document for charting the future directions of the Older Americans Act.

Both measures are designed to direct more resources to the so-called vulnerable elderly. One proposal would amend the definition of "greatest social need" to include vulnerable older persons. Another recommendation would allocate funds states under Title III according to the 70-plus population, rather than those 60 years or older.

At the outset, NP/ARCA wishes to emphasize, as strongly as possible, that we are not opposed to serving vulnerable elderly persons under the OAA. The existing definition of "greatest social need" under the OAA makes it clear that the vulnerable aged are a priority group for receiving services. For example, current law states "greatest social need" meaning the need caused by noneconomic factors which include physical and mental disabilities.

However, NP/ARCA is opposed to redirecting more resources under the Older Americans Act to other groups when the aged minority participation rate is at all time low during this decade for both the supportive services and the elderly nutrition programs. The bottom line is that inadequate funding already exists to meet the services needs of aged minorities. The proposal to redirect more Title III funds to the vulnerable elderly will only create more havoc in terms of serving older minorities more equitably.

The 70-plus formula will work to the disadvantage of aged minorities because their life expectancy is shorter than that of older Whites.

Death rates are generally higher for minorities, except at very advanced ages, than for Whites. The net impact is that the proposed new formula would probably siphon off funds from older minorities.

For these reasons, we strongly oppose both these measures. We urge you to reject these proposals should they be forwarded during the reauthorization of the OAA.

Management Information System

Improved statutory language alone, of course, will not automatically assure greater equity for older minorities. An effective management information system is also necessary to measure whether the minority aged are effectively served.

The need to improve and systematize data collection is an indispensable first step in determining the adequacy of services. The present data collection system has many flaws. Older minorities, for example, may be counted several times when they receive multiple services, even though only one individual actually received services under the Older Americans Act. This has the effect of inflating the numbers of percentages of aged minorities served under Title III supportive and nutrition services, raising questions regarding the accuracy of published data.

The National Pacific/Asian Resource Center on Aging recommends the following to improve data collections:

. Administration on Aging initiate strategies, after conferring with national aging organizations, state and local offices on aging, statisticians, and others, to improve the accuracy and reliability of statistical reporting under the OAA.

. Area agencies on aging be required to maintain data concerning the number of percentage of minority persons 60 or older in the planning and service area. Minority groups should include Asian Americans, Pacific Islanders, Black, Hispanics, American Indians and Alutets.

. All area agencies be directed to conduct comprehensive needs assessments by race, color, and national origin.

. Area agencies maintain accurate records showing the utilization of services by race, color, and national origin.

Improve Title V for Pacific/Asians

The evidence is very clear and convincing that elderly Pacific/Asians have been under-represented in Older Americans Act services programs. A need also exists to increase the older Pacific/Asians participation in the Title V Senior Community Service Employment Program. The record for Title V is better than Title III, but there is room for improvement. In FY 1982, older Pacific/Asians accounted for 2.6% of all Title V enrollees. Much of this participation is attributed to Hawaii which has a high proportion of Pacific/Asians in Title V. Otherwise the FY 1982 figure would be even lower. For these reasons, the NP/ARCOA reaffirms that the Pacific/Asian elderly participation in the Senior Community Service Employment Program should be increased.

Conclusion

In conclusion, older Pacific/Asians have been underserved by Older Americans Act programs. Our proposed amendments to the Older Americans Act can help to overcome this problem. Moreover, our legislative and administrative recommendations can bring more Pacific/Asian aged and other older minorities into the mainstream of American life. We urge the committee to support these proposals.

Senator **Matsunaga**. We would be happy to hear from you, Mr. Crecy. Did I pronounce your name right?

Mr. **Crecy**. Crecy, that is correct, Mr. Chairman, good Irish name. Mr. Chairman and members of the subcommittee, particularly, Senator Cochran, NCCBA is very pleased to have the opportunity to testify before this reauthorization committee. We have a very comprehensive statement, and I want to make sure that this is available for the record. I did not know if it had been seen.

Senator **Matsunaga**. All your statements will appear in the record as though presented in full.

Mr. **Crecy**. Okay. And then for the sake of time, I am not going to regurgitate a lot of statistics. I think essentially NCCBA considers services to aged minority and the equitability of services to aged minority one of the most important issues in the reauthorization of the Older Americans Act. It has become even more critical now because minority participation rates, as you know, in Title III-B happens to be declining.

I will not bore you with a whole bunch of statistics. That is in the comprehensive statement, but basically what it is is that aged blacks particularly have been negatively affected. Nearly 300,000 fewer Blacks have been serviced or have received service until Title III-B support services since 1985, 300,000 fewer Blacks. Now, I really become somewhat concerned when from 1981, 1982, 1983, 1984, U.S. Administration on Aging—because all of these stats are derived from that agency—indicates that all of a sudden those figures are no longer correct, or that they were not computed correctly, and that there may be some error rate in that. Well, if all of that time, even including the last reauthorization in 1982 and 1983, those figures were utilized. The data base that those figures were developed on are the same data base purportedly that has been used up until 1985 and 1986 figures. So I am kind of concerned about that.

We certainly feel that several measures are needed to help revise the downward slide of elderly minority participation in the Older Americans Act. Obviously, one of those is an accurate data base that we would encourage this committee to emphasize to the Administration that the collection of data on characteristics of those who participate in Older American Act programs is tantamount to better services to all individuals in the Older Americans Act, in particular minority concerns.

NCCBA favors new statutory language to promote the appointment of minorities to advisory committees and boards for area agencies and state agencies on aging. These advisory committees can be influential in determining what types of services are provided, where they are delivered within the community.

Mr. Chairman, NCCBA further urges this subcommittee, as I mentioned before, to emphasize the improvement on the reporting of minority services under the Older Americans Act. We are in opposition, and we are deeply concerned, about the number of proposals to target more scarce resources under the Older Americans Act to vulnerable elderly. NCCBA does not oppose servicing vulnerable older Americans. However, these recommendations typically involve health-related services which in the judgment of NCCBA are more appropriately provided through other legislation rather than the Older Americans Act.

Moreover these services to the vulnerable elderly will probably cost more and dilute existing and limited resources for current client groups under the Older Americans Act. It is our opinion that this does not make sense since minority participation rates for Title III support services and nutrition services are already falling sharply. Additionally, low income aged minorities have the greatest need of these services. For these reasons, NCCBA opposes the change of the formula for allocating the Title III funds on the basis of population 65 years and older rather than 60-plus as under the current law.

We oppose the amendment of the definition of greatest social need to include vulnerable older individuals. We oppose the establishment of community-based services if the emphasis is on providing expensive health-related services. In the area of Title IV, NCCBA has two major recommendations on the Title IV training and research and demonstration programs. First, we urge the Subcommittee on Aging to support existing priorities for funding demonstration projects responding to low income minority and limited English-speaking individuals. Second, we recommend that the 1987 Older Americans Act Amendments should promote career preparation training for minorities, especially in historical black colleges and universities. It is this needed emphasis of career level education that is most essential for attracting more minorities into the field of aging.

In the earlier Title V, we recommend that the current unit costs of $5,111 be adjusted. That the present 12 percent administrative cost cap be unbound upon national and state organizations and that it be raised to either 15 percent or the minimum 13.5. Thank you again, and I am available for questions afterwards. Thank you.

Senator MATSUNAGA. Thank you, Mr. Crecy.

[The prepared statement of Mr. Simmons, represented by Mr. Crecy, follows:]

TESTIMONY BY

SAMUEL J. SIMMONS
PRESIDENT
THE NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

BEFORE THE

SUBCOMMITTEE ON AGING
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON

REAUTHORIZATION OF THE OLDER AMERICANS ACT
NEEDS OF OLDER MINORITIES

APRIL 23, 1987

Mr. Chairman and Members of the Subcommittee on Aging, the National Caucus and Center on Black Aged welcomes the opportunity to testify on the reauthorization of the Older Americans Act. We are especially pleased that you have designated one specific hearing on the special needs of older minorities.

A. Serving Aged Minorities More Equitably

NCBA considers equitable treatment for minorities to be the single most important issue for the reauthorization of the Older Americans Act. This becomes even more critical now because the minority participation rate in the Title III-B supportive services and senior centers program has declined by 24.7 percent during this decade, from a high of 21.9 percent in fiscal year 1980 to a low of 16.5 percent in 1985. The harsh reality is that the minority participation rate has dropped every year during this decade except for FY 1982, when it remained unchanged.

A similar pattern exists for the Title III-C nutrition program for the elderly. The minority participation rate has declined every year since 1980, except for 1983. Overall, the minority participation rate has dipped by 13.7 percent, from 19.0 percent in FY 1980 to 16.4 percent in 1985.

Aged Blacks have been negatively affected. In fact, nearly 300,000 fewer Blacks received Title III-B supportive services in 1985 than in 1980. The aged Black participation rate has plummeted by 23.0 percent during this period, from 13.9 percent in 1980 to 10.7 percent in 1985.

The aged Black participation rate for the elderly nutrition program has declined by 9.8 percent during this decade, from 11.2 percent in 1980 to 10.1 percent in 1985. As a practical matter, the 1985 participation rates for all major elderly racial and ethnic minority groups are at an all time low for the 1980's.

I do not want to overwhelm you with a long litany of statistics. Our point is short and simple: A serious problem exists in serving older minorities more equitably under the Older Americans Act. Unfortunately, this dilemma is worsening, rather than improving. Virtually every major relevant study has concluded that minorities are underserved, including the 1982 Civil Rights Commission report, earlier equity studies, and other objective analyses of the issue.

B. Title III Recommendations

Several measures are needed to help reverse the downward slide for the elderly minority participation in Older Americans Act programs. The 1984 Older Americans Act Amendments emphasized that low-income aged minorities were a priority group for receiving services.

This provision helped to clarify that older minorities were a likely target group for receiving Title III services. However, a clear-cut need exists to strengthen this language to emphasize that low-income older minorities should be served on the basis of their need for services. Equity studies show that the minority aged's need for services is normally about 2 to 3 1/2 times as great as for the non-minority elderly. NCBA strongly believes that the proposed statutory language can be a positive force in improving minority participation in Older Americans Act programs if this measure is appropriately monitored and implemented.

NCBA also favors new statutory language to promote the appointment of minorities on advisory committees and boards for area agencies on aging and state offices on aging. These advisory units can be influential in determining what types of services are provided and where they are delivered within the community. These decisions are often critical in deciding who is served under the Older Americans Act and how well they are served.

Mr. Chairman, NCBA further urges this Subcommittee to call upon the Administration on Aging to improve reporting requirements for minority participation in Older Americans Act programs. Moreover, AoA should issue regulations, program instructions, and other relevant information for regional AoA offices, state offices on aging, and area agencies on aging. Without these bare essentials, there will be no effective direction for improving minority participation in Older Americans Act programs.

C. Opposition to Provisions Impeding Participation by Minority Elderly

NCBA is also deeply concerned about a number of proposals to target more scarce resources under the Older Americans Act to the vulnerable elderly. NCBA certainly does not oppose serving vulnerable older Americans.

However, these recommendations typically invovle health related services, which, in the judgment of NCBA, are more appropriately provided through other legislation, rather than the Older Americans Act. Moreover, these services for the vulnerable elderly will probably cost more and dilute existing limited resources for current client groups under the Older Americans Act. In our opinion, this does not make sense since the minority participation rate for Title III supportive and nutrition services has already fallen sharply. Additionally, low-income aged minorities have the greatest need for these services.

For these reasons, NCBA opposes measures to:

- o Change the formula for allocating Title III funds on the basis of the population 65 or older, rather than 60-plus as under current law.
- o Amend the definition of "greatest social need" to include vulnerable older individuals.
- o Promote the establishment of community-based services if the emphasis is on providing expensive health-related services.

D. Title IV Recommendations

NCBA has two major recommendations for the Title IV training, research, and demonstration program. First, we urge the Subcommittee on Aging to support the existing priority for funding demonstration projects responding to the needs of low-income, minority and limited English-speaking individuals. This provision can be an effective tool, if appropriately funded, to develop demonstrations which can be replicated nationwide for improving the delivery of services to older minorities. We urge the Subcommitte on Aging to work with the Appropriations Committe to insure that this provision is adequately funded.

Second, NCBA recommends that the 1987 Older Americans Act Amendments should promote career preparation training for minorities, especially at historical Black colleges and universities. This is needed to emphasize that career level education for minority group individuals is a high priority goal. It is also essential to attract more minorities into the field of aging.

E. Title V Recommendations

NCBA is also calling for three major changes to benefit older minorities under the Title V Senior Community Service Employment Program (SCSEP). First, we urge that the program be continued and the authorized funding level be increased to permit more aged minorities and other low-income older Americans to participate.

Second, we recommend that the current $5,111 average cost per enrollee be adjusted for the following reasons:

1. The current average cost has remained in effect for six years, although Title V operating costs have risen in recent years.
2. The Social Secrity payroll tax has increased, and will continue to rise during this decade.

3. Title V program administrators have been given new responsibilities by the Department of Labor--most notably in the areas of equitable distribution and higher goals for unsubsidized placements.

Moreover, it is quite likely that the minimum wage will rise in the near future.

Third, NCBA supports a 15-percent administrative cap, the same limit that exists for most employment and training programs. The present two-step reduction--from 15 percent to 13.5 percent in fiscal year 1986 and then to 12 percent in 1987--will adversely affect Title V operations, particuarly for older Americans and the communities they serve. It will also be detrimental to national minority sponsors because they do not have the economies of scale that the larger sponsors have.

Some Title V participants will inevitably lose their jobs because of the lower cap. As a practical matter, sponsors will be forced to consolidate their operations by closing down smaller projects to lower their administrative costs. Unfortunately, this development may be especially harmful for the rural elderly. The bottom line is that the program may develop an urban bias, although poverty is generally more heavily concentrated in rural areas than in the suburbs or urban areas.

F. Conclusion

In conclusion, NCBA wishes to express its sincere appreciation to the Subcommitte on Aging for this opportunity to testify today. We reaffirm our support for the

Older Americans Act. We believe that this historic legislation has benefited senior citizens, local communities, and our nation.

We, therefore, urge that the Older Americans Act be extended for at least three years with increased authorized funding levels. We further urge that our proposals to make the legislation more responsive to older minorities be adopted when the Congress considers the 1987 Older Americans Act Amendments.

These measures are much needed. They are realistic. And, they will help to improve the Older Americans Act for the elderly of today and tomorrow, as well as our nation.

Mr. Chairman, I also ask unanimous consent to insert in the hearing record NCBA's comprehensive statement on the reauthorization of the Older Americans Act. This longer statement provides more detailed information concerning NCBA's position on a wide range of issues relating to the extension of the Older Americans Act.

Thank you for your courtesy. I shall be glad to respond to any questions that you may have.

Senator MATSUNAGA. Mrs. Minton, we shall be happy to hear from you now.

Mrs. MINTON. Thank you, Senator. I have lived in Kensington, MD, for 27 years. Senator Matsunaga and Senator Cochran, and honorable committee members, I am Mrs. Iwalani Minton. The Honorable Winona Kealamapuana Ellis Rubin, Director of the Department of Social Services and Housing, a native Hawaiian, and former President and Chief Executive Office of Alu Like, Incorporated, a statewide community-based Hawaiian organization, regrets that the state legislature conference committee hearings prevent her from being present today. She has asked me to make a brief statement on her behalf.

Mr. Chairman, and members of the committee, Aloha. I wish to extend my appreciation for your invitation to testify in support of the reauthorization of the Older Americans Act of 1965, as Amended, through passage of the proposed Older Americans Act of 1987.

As Dr. Jeanette Takamura, Director of the Executive Office of Aging for the State of Hawaii, testified on March 31 before this subcommittee, the State of Hawaii is engaged in planning, program development and policy formulation for the elders in the state whose number is expected to increase by more than 90 percent in the next two decades.

Resources provided by the Older Americans Act can be instrumental in addressing the broad spectrum of needs including (a) services associated with access to services—that is transportation, outreach, information and referral—(b) in-home services such as homemakers, health aids, visiting and telephone assistance, chore maintenance, support services to families; and (c) legal assistance such as tax, financial insurance and other counseling.

We support Dr. Takamura's recommendations. In addition, I wish to offer the following comments relative to provisions of the Act as it relates to minorities and specifically native Hawaiians defined as those whose ancestors were natives of Hawaii prior to 1778.

To ensure appropriate minority membership on advisory councils, the bill should include a requirement that minority representation on councils be in proportion to the minority's representation in the total population of the area served by the council.

Currently, Hawaiians comprise over 19 percent of the state population, and approximately nine percent of those are 60 years and older, but they are not represented in that proportion in existing advisory councils.

Ethnic minority representation sometimes may be inadvertently overlooked or affirmative outreach insufficient to encourage more active participation. To reaffirm the commitment of Congress to the language of the act which focuses on serving persons with the greatest economic need and the greatest social need in a culturally sensitive manner. The bill should be amended to provide some flexibility in hiring personnel in Section 307(a)(20)(B). The language indicates the singular.

The language should read: "(B) to designate individual(s) employed." This allows for flexibility in employing at least one person, but possibly more to enable appropriate ethnic groups to have representation which will ensure sensitivity to their culture and language.

To consider a provision in the Act which will provide specific resources for native Hawaiians as Native Americans. Native Americans encompassing native Hawaiians are included in existing Congressional legislation to provide vocational education, mental health, employment, community, social and economic development, religious freedom and culture and the arts. Inclusion of Native Americans in the Older Americans Act and future legislation is appropriate and consistent with Congress' intent.

The provisions of the Older Americans Act are an important means of enabling native Hawaiians as well as all older Americans to sustain themselves with dignity in their later years through an array of coordinated programs supported by this act. Therefore, we strongly support the reauthorization. I sincerely appreciate the opportunity to testify at this hearing, and thank you for continuing the efforts on behalf of Older Americans.

Senator MATSUNAGA. Thank you very much, Ms. Minton. Right on time. You Hawaiians are marvelous people. [Laughter.]

[The prepared statement of Mrs. Rubin, represented by Mrs. Minton, follows:]

JOHN WAIHEE
GOVERNOR

WINONA E. RUBIN
DIRECTOR

HAROLD FALK
DEPUTY DIRECTOR

ALFRED K. SUGA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF SOCIAL SERVICES AND HOUSING

Statement of

Winona Kealamapuana Ellis Rubin
Director, Department of Social Services & Housing
State of Hawaii

Presented to
The U.S. Senate Subcommittee on Aging,
Committee on Labor and Human Services

April 23, 1987

Senator Matsunaga and honorable committee members. I am Mrs. Tooley Minton. The Honorable Winona Kealamapuana Ellis Rubin, Director of the Department of Social Services and Housing, a native Hawaiian, and former President and Chief Executive Officer of ALU LIKE, Incorporated, a statewide community-based Hawaiian organization, regrets that the state legislature conference committee hearings prevent her from being present today. She has asked me to make a brief statement on her behalf.

STATEMENT

Mr. Chairman and distinguished members of the Senate Subcommittee on Aging. Aloha. I wish to extend my appreciation for your invitation to appear before you today to testify in support of the reauthorization of the Older Americans Act of 1965, as amended, through the the passage of the proposed "Older Americans Act of 1987."

As Dr. Jeanette Takamura, Director of the Executive Office on Aging for the State of Hawaii testified on March 31 before this subcommittee, the State of Hawaii is engaged in planning, program development and policy formulation for the elders in the state who are expected to grow by more than ninety percent (90%) in the next two decades.

The resources provided by the Older Americans Act can be instrumental in addressing the broad spectrum of needs including (A) services associated with access to services (transportation, outreach, information and referral); (B) in-home services (homemakers, health aids, visiting and telephone assistance, chore maintenance, support services to families); and (C) legal assistance (tax, financial insurance and other counseling).

We support Dr. Takamura's recommendations (Appendix A). In addition, I wish to offer the following comments relative to provisions of the Act as it relates to minorities and specifically native Hawaiians -- those whose ancestors were natives of Hawaii prior to 1778.

- To ensure appropriate minority membership on advisory councils, the bill should include a requirement for minority representation on councils to be in proportion to the minority's representation in the total population of the area served by the council.
  - Currently, Hawaiians comprise over 19% of the state population and approximately 9% of those 60+ years and older, but they are not represented

in that proportion on existing advisory councils. Ethnic minority representation sometimes may be inadvertently overlooked or affirmative outreach insufficient to encourage more active participation.

- To reaffirm the commitment of Congress to the language of the Act which focuses on serving persons with "the greatest economic need" and "the greatest social need" in a culturally sensitive manner, the bill should be amended to provide some flexibility in hiring personnel in Section 307(a)(20)(B). The language indicates the singular.
  - The language should read: "(B) to designate individual(s) employed..." This allows for flexibility in employing at least one person, but possibly more, to enable appropriate ethnic groups to have representation which will ensure sensitivity to their culture and language.
- To consider a provision in the Act which will provide specific resources for native Hawaiians as Native Americans.
  - Native Americans (encompassing native Hawaiians) are included in existing Congressional legislation to provide vocational education, mental health, employment, community social and economic development, religious freedom, and culture and the arts. Inclusion of Native Americans in the

> Older Americans Act and future legislation is appropriate and consistent with Congress' intent.

The provisions of the Older Americans Act are an important means of enabling native Hawaiians as well as all older Americans to sustain themselves with dignity in their later years through an array of coordinated programs supported by this Act. Therefore, we strongly support the reauthorization of the Older Americans Act.

I sincerely appreciate the opportunity to testify at this hearing and thank you for continuing efforts on behalf of older Americans.

APPENDIX A

Excerpt from Testimony of:
Dr. Jeanette Takamura, Director
The Executive Office on Aging
March 31, 1987

Areas of Focus:

The development of a community-based long term care system and of component programs and services. Almost three-fourths of all informal help received by older people is provided by family members or friends. Nonetheless, geographic mobility, higher rates of female labor force participation, reduction in family size, and the desire on the part of older adults to remain self-sufficient and in familiar surroundings mean that traditional caregiving assumptions and arrangements are often strained. With increasing incidence, family members who wish to be involved in caregiving are finding themselves in need of supportive services and programs such as adult day care, adult day health, home health care, chore, and other personal care and respite assistance. These needs may be expected to rise considerably in the years ahead, given the mound of evidence which indicates that more young old and old persons are serving as caregivers to the old old and that the incidence of Alzheimer's and related disorders increases markedly with advanced age.

The development of coordinated aging data systems which permit the retrieval of useable information for planning, evaluation, policy formulation, and other purposes. Concomittant to the support of essential programs and services for the older adult population must be the development of comprehensive aging data systems which permit the retrieval of usable information for planning, evaluation, policy formulation, and other purposes on a statewide basis. Incentives must be given to agencies and programs to examine existing data bases and to collaborate in the development of coordinated data systems. If such collaboration does not occur, these agencies and programs will continue to gather and generate data which can not be aggregated or compared by the aging network on a statewide basis.

The development and expansion of protective services mechanisms. The development and expansion of protective services mechanisms, including the ombudsman program, is necessary in light of rising rates of elder abuse and neglect. The expansion of community-based long term care is inevitable in light of the fact that it is generally less costly and that such are tends to be preferred by older adults. Older adult consumers of community-based services should be given the same adequacy of care guarantees which patients in long term care facilities are offered through the ombudsman program.

Other Comments Pertinent to the Reauthorization of the Older. Americans Act:

In addition to the recommendations suggested in the preceding discussion, we are in support of the recommendations which have been offered by the National Governor's Association and the National Association of State Units on Aging. May we note moreover:

- that our experience suggests that states should be permitted to selectively apply cost-sharing principles to those programs which are funded by the Older Americans Act.

- that input received from our aging network does not support changes in the age formula for allotting Older Americans Act funds.

- that there is widespread agreement that the Older Americans Act must reflect a stronger commitment to the protection of older adults from abuse, neglect, and exploitation; to community-based long term care services; and to the support of family members and others who are providing care to older persons.

Senator MATSUNAGA. Dr. Parks.

Dr. PARKS. Mr. Chairman and Senator Cochran, I am Arnold Parks, Professor of Sociology at Lincoln University, located in Jefferson City, Missouri. I speak today as an academician on behalf of America's rural black elderly who are affected in one way or another by the Older Americans Act of 1965 and its subsequent amendments.

I want to thank you for providing me with this opportunity to testify. In the interest of time, I shall briefly address the concerns of America's rural black elderly and ask that you accept my written testimony for the record.

More than 18 months ago, the United States Department of Health and Human Services of the Administration on Aging, through its Coordinated Discretionary Grants Program awarded me funding to conduct an in-depth study and collect baseline information on the social perspectives of rural black elderly in the southern states of Arkansas, Mississippi and Tennessee.

In its funding decision, the Administration on Aging considered that although research activity in the field of social gerontology has rapidly expanded over the past three decades, very little of this research thrust has focused on rural elderly persons, and even less so on rural black elderly. Although 80 percent of all black elderly persons in the United States reside in urban areas, it is significant that the remaining 20 percent isolated and sometimes forgotten black elders reside in rural communities. These persons should not be overlooked nor given uneven consideration and support. Although not yet conclusive, the findings of my research tends to indicate the following selective problems and conditions associated with America's rural black elderly.

First of all, as might be expected, on the average the income of those persons tends to be consistently lower than that of their urban counterparts, and a much higher proportion of rural than urban black aged have incomes below the poverty level.

Secondly, rural black elderly tend to occupy a disproportionate share of the nation's substandard and dilapidated housing.

Thirdly, sanitary conditions many times were evidenced as being primitive and totally inadequate for the 20th century. This factor can have numerous negative spin-offs which include higher incidence of illness, a shorter life expectancy and generally a lower standard of living.

Next, older blacks living in rural areas are typically the people left behind. While many of these persons reside in small towns rather than farm communities, nevertheless these rural hamlets are many times without essential services for a quality life.

Next, public transportation is frequently non-existent. The net impact is that large numbers of rural black elderly persons live in solitary confinement and are essentially cut off from their friends, family and essential service providers.

And finally, most rural black elderly feel, and rightly so, that they do not have convenient access to adequate health services and other health personnel. Physical and mental health needs of rural black elderly are not readily treated in their local communities.

The above listing is only a brief synopsis of a few significant findings of this research effort. It should be clearly understood that, indeed, each of the above concerns and/or problems might in some regard be characteristic of all rural elderly and not just rural black elderly persons. Nevertheless, the fact remains that the former mentioned category of persons appear to be more severely affected. Equally important is the fact that a full reauthorization of the Older Americans Act will not necessarily directly or fully address each of the above-cited conditions.

However, a reauthorization of the act would guarantee to rural black elderly and other minority elderly groups that a basic continuum of services would continue to be provided. On the other hand, the mere reauthorization or continuation of the act is not enough. There must be a commitment and a dedication to including provisions in the act which guarantees relief and an enhanced quality of life for older rural blacks and others.

One means of strengthening the Older Americans Act in order to benefit rural black elderly, other minorities, and the vulnerable elderly is to place emphasis on those provisions of the act which relate to the delivery of services. Based upon my research findings, therefore, I would urge that in the act consideration is given to a special targeting of services for rural black elderly and older minorities that is in direct proportion to their needs.

There are a couple of other recommendations I would suggest. Area agencies on aging be required to conduct annual needs assessments, and finally I would recommend that for low income aged minorities a priority be given to Title III supportive and nutrition services. I think with those strengthening factors in the act, minority and older rural elderly will be well served. Thank you.

Senator MATSUNAGA. Thank you, Dr. Parks.

[The prepared statement of Dr. Parks follows:]

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BY THE STATE OF MISSOURI
JEFFERSON CITY, MISSOURI 65101

TESTIMONY

BY

ARNOLD G. PARKS PH.D.

LINCOLN UNIVERSITY
(MISSOURI)

ADDRESSING

REAUTHORIZATION OF THE OLDER AMERICANS ACT

SUBMITTED TO

SUBCOMMITTEE ON AGING

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

APRIL 23, 1987

Chairman Matsunga and distinguished members of the sub-committee, I am Arnold Parks Professor of Sociology at Lincoln University located in Jefferson City, Missouri. I speak today as an academician on behalf of America's rural black elderly population who are affected in one way or another by the Older Americans Act of 1965 and its' subsequent amendments.

I want to thank you for providing me with this opportunity to testify. In the interest of time, I shall briefly address the concerns of America's rural black elderly and ask that you accept my written testimony for the record.

More than eighteen (18) months ago, the United States Department of Health and Human Services through the Administration on Aging Coordinated Discretionary Grants Program awarded me funding to conduct an in-depth study and a collection of baseline information on the social perspectives of rural black elderly persons in the southern states of Arkansas, Mississippi, and Tennessee. While the research team and myself are currently in the process of writing up the results of our investigation, my observations today are based upon some preliminary but significant findings of these data. Hopefully, the information shared with will be helpful as you consider the issues both philosophically and technically related to the reauthorization of this vital piece of legislation.

In its' funding decision, the Administration on Aging considered that although research activity in the field of social gerontology has rapidly expanded over the past three (3) decades very little of this research thrust has focused on rural elderly persons and even less so on rural black elderly. Although eighty (80%) percent of all black elderly persons in the United States reside in urban areas, it is significant that the remainding twenty (20%) percent of "isolated and sometimes forgotten black elders" reside in rural communities. These persons should not to be overlooked nor given uneven consideration and support.

While not yet conclusive, the findings of my research tends to indicate the following selective problems and conditions associated with America's rural black elderly:

* As might be expected, on the average, the income of these persons tends to be consistently lower than that of their urban counterparts and a much higher proportion of rural than urban black aged have incomes below the poverty level.

* Rural black elderly tend to occupy a disproportionate share of the nation's substandard and dilapidated housing. Quite often, greater extremes of deprivation are more starkly apparent in the rural slums than in the central cities. Ramshackle, deteriorating, and structurally unfit housing was readily evident among rural black elderly in the three states in which we conducted our research. Most homes occupied by our respondents had been in their family for generations.

* Sanitary conditions many times were evidenced as being primitive and totally inadequate for the 20th century. This factor can have numerous negative spin-off which include higher incidence of illness, a shorter life expectancy, and generally a lower standard of living.

* Older blacks living in rural areas are typically the "people left behind". While many of these persons reside in small towns rather than farm communities, nevertheless these rural hamlets are many times without essential services for a quality life.

* Public transportation is frequently nonexistent. The net impact is that large numbers of rural black elderly persons live in "solitary confinement" and are essentially cut off from their friends, family, and essential service providers.

* Most rural black elderly feel, and rightly so, that they don't have convenient access to adequate health services and other health personnel. Physical and mental health needs of rural black elderly are not readily treated in their local communities.

The above listing is only a brief synopsis of a few significant findings of this research effort. It should be clearly understood that indeed each of the above concerns and/or problems might in some regard, be characteristic of all rural elderly and not just rural black elderly persons. Nevertheless, the fact remains that the former mentioned category of persons appear to be more severely affected. Equally important, is the fact that a full reauthorization of the Older Americans Act will not necessarily directly or fully address each of the above cited conditions. However, a reauthorization of the Act would guarantee to rural Black and other minority elderly groups that a basic continuum of services would continue to be provided. On the other hand, a mere reauthorization or continuation of the Act is not enough. There must be a committment and a dedication to including provisions in the Act which guarantee relief and an enhanced quality of life for older rural black and others.

One means of strengthening the Older Americans Act in order to benefit rural black elderly, other minorities, and the vulnerable elderly is to place emphasis upon those provisions of the Act which relate to the delivery of services. Based upon my research findings therefore I would urge that in the Act consideration be given to a special targeting of services for rural Black elderly and older minorities that is in direct proportion to their needs. Such a statement would take into consideration those persons with the greatest economic needs. This position would definitely benefit older minorities, because they typically have a poverty rate which is two to three times as high as the non-minority elderly population.

A second recommendation for consideration is one whereby all Area Agencies on Aging should be required to conduct annual needs assessments regarding the effectiveness of their service delivery systems in reaching out to minority and other low income older Americans. If this were done, Area Agencies on Aging would then be required to revise their funding formulas in order to more effectively target their available resources.

Third, despite the fact that the 1984 Older American Act amendments emphasize that low income aged minorities should be a priority group to receive Title III supportive and nutrition services, this has not necessarily occurred. Hopefully, strong legislation would counteract the declining minority participation rate in Older Americans Act programs at both the rural and urban levels.

Senator MATSUNAGA. Do you have any questions, Senator Cochran of the panel?

Senator COCHRAN. I have a few, Mr. Chairman. Would you like for me to proceed on that?

Senator MATSUNAGA. Yes, would you please.

Senator COCHRAN. I appreciate that. I am very impressed with the quality of testimony, let me say that, Mr. Chairman, that we have heard this afternoon from all of the witnesses. I think we have benefited greatly from the experience and the information that we have had revealed to us today, in the studies that have been undertaken, from the personal experience of those who make up the panel about how these programs do or do not reach those intended to be served, and some of the things that might be changed to help improve the access to the services and the quality of the services, the meaningful change in the lives of older citizens that that could bring. So I want to thank all of you for the help that you have provided to us today.

I am sincere in saying that. One thing we do not do enough of here in the Congress is listen to people who have personal experiences and expertise in some of these areas of interest and jurisdiction because I know we profit by having listened and learned. You have made that possible for us today. In the effort to embark upon a more effective outreach program, I wonder how, if anyone has a statement to add to what has already been said. We reach out to those who do not have access to what you might consider to be normal channels of communication, who may not be able to read if you send out letters. And people just assume if you send out a circular acquainting the community with the availability of a center or a service, and that that is going to carry the information.

It does not necessarily do it. I wonder how we go about communicating better with the elderly, poor, particularly the minority poor who are not able to read, and it is just not like that is a small number. They are a large number.

Mr. CRECY. Thank you, Senator Cochran. That reminds me of the testimony that my boss, Sam Simmons, gave before the House Committee on Aging about 3 weeks ago. He says, you know, every year we come back in these oversight hearings and we talk about particularly since 1982 our depreciating, declining minority participation rates in the programs, and we talk and we talk and I think in the 1984 reauthorization there were 29 instances of emphasis added to the act for increased, to increase minority in both income individuals' participation in the Older Americans Act programs.

But you know, it really gets down to a will that comes from the top, and it has to begin with the U.S. Administration on Aging. We had with the previous commissioner regional meetings around the country, targeted towards the RPDs in various States targeted towards increasing minority participation rates. After the meeting and the change of the chair, of the new commissioner coming on, to this date we have never been contacted by RPDs, at least since NCCBA. I cannot speak for the rest of my colleagues. By RPDs or states about what, if there were problems, technical assistance could be rendered. What our opinions were about how they were intending to address the issue of our declining minority participation rates.

So it takes more than just the rhetoric that is on paper. It takes a personal commitment on the part of the Administration, and I think that with that commitment being voiced and obviously manifested to the rest of the network that it is serious about increasing minority participation rates, that it is reviewing state plans. Because it is not a question of communicating to folks that are illiterate. The Title V network services probably more low income—well, it is 100 percent, almost 100 percent low income, poorly educated individuals. But they are able to outreach and gather them because there was a commitment on the part of the national and state sponsors to recruit those individuals into the program.

So it really comes down to a point that the U.S. Administration on Aging and the State units on aging and the area agencies on aging have to get beyond the rhetoric of language and get down to the activity of implementation.

Thank you very much.

Senator **Cochran**. Any other observations? Dr. Brown?

Dr. **Brown**. I would like to make a statement, Senator, as one who struggles everyday to meet these needs in Mississippi. We have waiting lists of clients, in our meals and homemakers programs. I would suggest that you all take a look at the formula by which the states are funded. Right now it is percentage of population over 60. Please look at risk factors: the percentage of minorities in a given state, the percentage of low income in a given state. If we put the preference language in the targeting provisions, I think it strengthens a consistent commitment if we look at the formula by which we allocate monies to the states.

I would also suggest that we look seriously at some cost sharing provisions, demonstration projects that would study the impacts of fee for services or sliding fee scales which should be plowed back into services for low income minorities, as another suggestion. I would also like to guarantee some of my friends from the national organizations, that everyday we are out there trying to meet the needs to the greatest extent that we can. And we make that commitment, both the state directors and the area agency directors as well.

Senator **Cochran**. Thank you.

Ms. **Kamikawa**. Senator Cochran, I think there is a crucial issue that you have raised here with respect to how do you reach individuals who may not have the capability, language capability either because they are illiterate and/or not well educated, and/or that they do not speak the language, that they may be monolingual.

I think that, in fact, when we look at a system that is created for a monolith, for middle class monolith, then you are talking about obscuring the problem around minorities who may not have access. There is, in fact, in most communities and across the community informal systems that work for minorities, that are not being tapped and utilized to the extent that they can make the system effective. I think the closer look at that, the process of getting that individual into the system may, in fact, answer the crucial issue about written material. That in fact there are ways to do that. You need to be able to utilize all of the existing informal networks that do exist in that society.

Senator **Cochran**. That was an experience that the U.S. Census Bureau has had in trying to develop a higher degree of participation in its program. In the past Congress, I happened to chair a subcommittee that had jurisdiction over the Census Bureau. We had hearings in both New York City and in my state of Mississippi trying to determine what new procedures involving community leaders, those that might be looked upon for leadership in finding out whether or not it was good to participate in this, or whether or should be done. We had participation from the Mississippi band of Choctaw Indians, as an example. And also involving the black community, particularly the ministers in a program of public support and encouragement about participation in this program. That it was something that would benefit the community, and the community would suffer if they did not benefit because the numbers would be inaccurate and distorted.

So it was a massive education project that was attempted to test these new procedures to see if they would work better, and I am happy to report that one of the things that was done last year was the cosponsorship of a conference involving many of these organizations who are represented here today to determine how we could get a more accurate account in the census of the elderly population, and also how we could get more accurate information, economic information, other information to help solve some of the problems that have been discussed today by some of the witnesses.

That conference was held here in Washington last year, and many of you participated in it, and I think we are making progress in trying to help solve some of those problems anyway. I hope that with the appropriation of some special funds which we earmarked for that purpose that we will see that program improve. Thank you, Mr. Chairman.

Senator **Matsunaga**. Thank you, Senator Cochran. What bothers me here is that the Administration has testified that there has been no decline in services to minorities, and well perhaps new figures which the Administration will present will show that. I do not know. I am extremely doubtful from what you say today. What figures, for example, have each of you used to indicate that the services have, in fact, declined where minorities are concerned?

Ms. **Lacayo**. Senator, all four national minority organizations in 1983 were called in 1983 to a series of regional meetings by the Administration on Aging to meet with all their regional directors and the states in those respective regions. The purpose of these meetings was to discuss the concern that the Administration on Aging's statistical reporting system was revealing a drop in minority participation rates. Now this issue was brought to us by the Administration on Aging.

In subsequent years, the issue has been raised again to us not only by the Administration on Aging, but also by the National Association of State Units on Aging and the National Association of Area Agencies on Aging. These are not our prefabricated statistics. Interestingly enough, the only program where there is an accurate counting of participation ratios is Title V, the Senior Community Service Employment Program, because we are mandated on a quarterly basis to give very specific compliance data. We do not count a person three times because he or she comes to a nutrition site and receives nutrition services then outreach services, and then information and referral services. In title III services, that one individual is counted three or five times. My statistics would go up very enormously if I counted Mr. Sanchez three or five times for one program.

So I would say that we are dealing first with a problem of not getting accurate data. With respect to the data we presented to you, these statistics are what has been presented to us by the aging network. That is why I am rather astounded that now, within a year's period, the Administration on Aging says all of a sudden that minority participation is even better in some areas, and that, in fact, there has been no decline. So should we call this a "whitewash"? I really believe that that is the situation. Additionally we are dealing with a program that we all know has limited dollars. Some people think the Older Americans Act is this humongous "pie in the sky" with endless dollars for services that are much needed. We all know that that is not a reality. The reality is that the pie is very small, and that it is decreasing every year because the number of older persons is increasing.

Now when are we going to make some cold decisions as to how that limited pie is going to be divided and how those services and to whom the services are going to be delivered? Even if one uses the new phrase "vulnerable," certainly minority older persons are a major part of that group. They are in triple jeopardy. They are old, and poor, and they are minorities. What we have here is somebody thinking that they are being made to look bad when, in fact, they are the ones who raised the issue of the decline in minority participation.

The other issue, I think, that has to be brought to the table is that we national minority aging organizations were created originally by the Administration on Aging to remedy the very serious need for training and technical assistance of minority groups across the country, but the resources we have developed with federal funds have not been used. We do not claim to speak in behalf of every single Hispanic elderly person in the nation. But we do say that over a period of years we have refined capabilities that we can bring to the aging network, and we are not called upon to bring that expertise to the table. We do not have minorities getting contracts in local communities to provide aging services. Our people simply cannot compete with entrenched contracting mechanisms.

We minorities do not participate enough in training programs. Our personnel are not moving up the professional ladder. Senator, we are saying we are disenfranchised.

Senator MATSUNAGA. Thank you very much, Ms. Lacayo.

Ms. LACAYO. Very simply——

Senator MATSUNAGA. Did any of you have a short additional statement? We are running overtime. The next panel is already late. If you really have to say something very briefly, you may. Otherwise, you can submit your further remarks in writing for the record.

Ms. LACAYO. Thank you, Senator.

Ms. KAMIKAWA. Senator Matsunaga, may I just include that one of my board members also wrote a paper on elderly Hawaiians that I would like to submit for the record.

Senator MATSUNAGA. By whom is it?

Ms. KAMIKAWA. Dr. Yuen at the University of Hawaii.

Senator MATSUNAGA. Dr. Yuen. Oh, yes. It may be submitted for the record.

Ms. KAMIKAWA. Thank you.

[The article referred to above follows:]

ELDERLY HAWAIIANS IN A CHANGING SOCIETY

Sylvia Yuen Schwitters, Ph.D. and Inez Ashdown*

Photo: [illegible]

Like the other native American groups, Hawaiians have witnessed the disintegration of their once stable society, the decimation of their people, and the denigration of their traditional customs. These experiences have left their mark, but there is a growing sense of pride, ethnic identity, and optimism among the Hawaiian people and an awakening appreciation for their culture. Older people are central in this contemporary framework, as they were in the past, for they are the reservoirs of knowledge. Hawaiian heritage and its continuance are ensured when that knowledge is shared with future generations.

The Elderly Hawaiians in Old Hawai'i

An examination of the elderly's place within the societal structure reveals how the old were regarded in Hawai'i prior to substantial Western influences. The early Hawaiians lived in a community and family in which an orderly system of status, responsibilities, and relationships prevailed. A clearly defined hierarchy existed which was composed of the following groups: the ali'i or ruling class of chiefs; the *Kahuna*, priests or experts; the *maka'ainana*, people in general or commoners; and the *kauwá*, who were outcasts or slaves.

The *kapu* system of prohibitions and restrictions governed the daily activities and behavior of people. No attempt was made to dominate the land or the plants and animals therein. Rather, there was a deep respect for the environment and an emphasis on living in harmony with nature. The second author remembers that during her childhood no one threw *opala* (trash) into the streams or sea or dirtied the earth. No one swam in or befouled the water to be drunk. The lesson remembered was: everything is a gift and everything should be shared. For this reason, for example, some fruit was always left on the trees for the birds; nothing was taken greedily or wasted as tomorrow's needs were always considered.

Family consciousness was a unifying and deeply felt force among the Hawaiians. *'Ohana,* the family clan or extended family, is derived from *'ohā,* the root of the taro plant, the staple in the Hawaiian diet, and signifies the same root of origin for its members. The *'ohana* included *makua*—the parents and all relatives of the parent-generation; *kūpuna*—grandparents and all relatives of the grandparent generation; and *keiki*—the children.[1] The *aumākua,* ancestor gods, also were included in the *'ohana.* They had the ability to take *kino lau,* that is, many bodies and forms, such as sharks, owls, rocks, and plants, and could change at will from animal to plant to mineral form.[2] Senior members of the family, including the *aumākua,* were respected. In them was invested the family authority, which was clearly recognized and obeyed, and their wisdom and knowledge were used to guide the *'ohana.* Communication with the *aumākua* was conducted through ritual and with reverence and was a normal part of *'ohana* living. The Hawaiians thus had a clear sense of their link and place in time and received emotional supports from spiritual ancestors as well as earthly members of the family.

Although all *kūpuna (kupuna* is the singular form), or members of the grandparent generation, were respected, the *hānau mua* was the acknowledged head of the *'ohana.* This status was determined, not by age or sex, but by genealogy. To illustrate, the chronologically younger, but eldest in the senior branch of the family served as *hānau mua* to an older cousin who was the eldest in a junior branch of the clan. The *hānau mua* was the accepted source of wisdom, the arbitrator of family disputes, the trouble shooter in family problems, and the custodian of family history.[3] If he or she proved consistently incompetent in the discharge of these responsibilities, the family discussed the problem and selected another elder with whom family members quietly consulted.

Children were cherished in the Hawaiian culture. Parents and grandparents were deeply involved in the *hanai ho'ohiwahiwa,* or rearing of the young. Boys and girls were taught sex appropriate tasks and educated in the knowledge of the stars *(kilo hoku),* designing and making implements for tapa work *('oihana kapala kua'ula),* or deep sea fishing *('oihana ku'ula)*—whatever profession the parents and grandparents engaged in.[4] The *hiapo,* first born child, if a girl, was adopted, or taken as *hānai,* by the maternal grandparents, and if a boy, was the *hānai* of the paternal grandparents. The child was given outright in a binding agreement when the parents said in the presence of others, *"Nau ke keiki kukae a na'au,"*—I give this child, intestines, contents and all. For the Hawaiians, emotions, intelligence, and character were associated with the guts or intestines, rather than the heart or brains, the first connection to the life giving force being the *piko,* or umbilical cord.[5] The *hānai* child knew his or her biological parents and was usually visited by them, but belonged to the grandparents. The Hawaiians placed great value on knowing the family genealogy, ancestor gods, and traditions. Because there was no written language to record this history, the *hiapo* became the living history book of the *'Ohana.* Grandparents served

E m hele i ka na'auao o ko kakou ho'oilina e ola mau

Share the knowledge of our heritage that it may continue

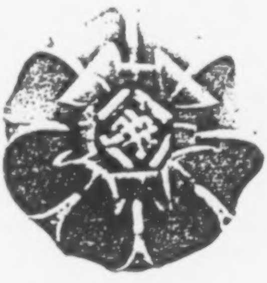

Photo Frank R. Butecho

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[1] M.K. Pukui et al., *Nana I Ke Kumu (Look to the Source),* Vol. 1, (Honolulu, Hui Hanai, 1972).

[2] *Ibid.*

[3] *Ibid.*

[4] S.M. Kamakau, *Ka Po'e Kahiko—The People of Old,* (Honolulu, Bishop Museum Press, 1964).

[5] Pukui, *Look to the Source, op. cit.*

Photo: Carol Severance

as mentors and imparters of knowledge regarding social and religious customs, genealogical chants, *kapu* (restrictions, taboos), and specialized skills and knowledge. The relationship between grandparents and grandchildren was generally very close and one of deep affection—with the elders serving as a link to the past and in the development of the young. In time, the *hiapo* would assume a position of responsibility, serve as consultant and arbitrator during family crises, and gain the respect and veneration accorded aged members of the *'ohana*.

An Evolving Hawaiian Society

The Influence of Non-Polynesians

From an isolated, neolithic culture maintained by a subsistence economy, Hawai'i has evolved into a multiethnic, modern society with all its attendant advantages and disadvantages—instant communication with the rest of the world, high rises, daily jets, super highways, and fast foods. The external forces which served as catalysts to transform the early Hawaiian way of life were introduced by people who were associated with exploration and trade, the promulgation of the Christian faith, agricultural enterprises, and the United States, as officials or private citizens. The influx of non-Polynesians to the Hawaiian Islands began with the arrival in 1778 of the Englishman James Cook and the two ships he captained, the *Resolution* and the *Discovery*. His visit and subsequent voyages by other explorers, traders, and merchants made available to the Hawaiians iron implements, such as nails and knives, firearms and explosives, and goods from Western and Asian ports. In 1820 the first company of missionaries set ashore and were appalled by the "destitution, degradation, and barbarism" of the "almost naked savages."[6] They determinedly set out to win as many converts to the Christian doctrine as possible, to develop a written form of the Hawaiian language, and to educate the *ali'i* or chiefs, and eventually, the commoners. The realization that the systematic development of agriculture could yield handsome profits spurred the cultivation of sugar cane, and later, pineapple, on a large-scale basis. The labor shortage created by such ventures was solved by the induced immigration of plantation workers beginning with the Chinese in 1852 and followed by subsequent waves of Japanese, Filipinos and other ethnically diverse individuals. The overthrow of the monarchy and dethronement of Queen *Lili'uokalani* in 1893 paved the way for the dominant impact the United States would have on Hawaii —through commercial interests, the military, politics and government, and tourism.

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[6] G. Daws, *Shoal of Time—A History of the Hawaiian Islands*, (New York, The MacMillan Company, 1968)

Collectively, these four major influences altered the basic framework of Hawaiian society and moved the islands inexorably into the twentieth century. What are some of the changes elderly Hawaiians have observed occurring to their land and people? One of the most profound relates to the dramatic shifts in demography. Table 1 illustrates the downward trend in population among the Hawaiians, both in absolute numbers and in proportion to the total population, over the last hundred years or so, as well as the increases in all other ethnic groups. The entry of individuals of various ethnic groups, who often came initially to work on the plantations, can be traced by the data in Table 1. Although the Caucasians were among the first "outsiders," their growth occurred primarily after Hawaii figured prominently as a military and tourism center. The best available evidence indicates that there were no more than 300,000 Hawaiians at the time of Captain Cook's first visit, so the slightly more than 70,000 Hawaiians at the time of the first official census in 1853 represents less than one-fourth of the pre-European figure.[7] The devastating death rate resulted largely from the introduction of diseases by visitors from abroad to which the previously isolated Hawaiians had not developed immunities. Some believe that the disease factor was not solely responsible for the rapid decline of the native population. Young, a psychiatrist with the University of Hawaii School of Medicine, cites in "The Hawaiians" the saying *Nā kānaka 'oku'u wale aku no i kau 'uhane*—"the people dismissed freely their souls and died"—to explain the role which the loss of identity, prestige, and cultural elements played in affecting the will to live.

If not resulting in physical death, the press of the outside world certainly brought about the termination of a stable societal order. Although the *kapu* system provided useful guidelines for sanitation, public health, and the consumption of resources, the same system benefited the ruling class over the commoners and outcasts/slaves and was sometimes abused by the chiefs. The erosion of the *kapu* system and the rules which governed how individuals related to nature, their gods, and each other destroyed the underpinnings of a traditional way of life, and because there was no ready-made framework to replace it, many Hawaiians were left in a state of cultural confusion.

Cultural conflict was another legacy of the foreigners. The introduction of new behaviors, new viewpoints, new gods, and new ways of relating to one's children, mate, and parents resulted in the severe questioning, and, at times, rejection, of traditional values and institutions. This problem was compounded when children were exposed to standards and practices at variance with those espoused by their parents and grandparents. The charting of new identities and lifestyles with abundant, dissonant, and confusing directional markers was not without pain and anguish, and, for some, failure.

Another influence introduced by Westerners was the stress on the individual and on competition as the means to achieve goals. As this philosophy gained dominance in the new social order, whether in the educational system or business world, rewards, recognition, and success were awarded for personal achievement and production. The cornerstone of the "Hawaiian way" was in direct opposition to this concept, and there was no way of reconciling the two viewpoints. Hawaiians place great importance on human relationships. These affiliative values stress group over individual pursuits and the solving of interpersonal problems. Aggressive, challenging, and confrontative behaviors, or placing another individual in a position of embarrassment or discomfort, are avoided by the Hawaiians, or undertaken at the risk of personal anxiety and group censure. These qualities, taken out of the context of the culture's value system, have been misinterpreted and used to depict the Polynesians as "lazy," "easy going," and "shiftless." The Hawaiian people's achievements—often requiring great will, endurance, and toil—give lie to the view that they are without ambition or the capacity for hard work.

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The Hawaiians have developed a different route to the attainment of goals—a way which emphasizes caring for people and the land. In the long run, this philosophy may be best suited for living in an island environment with a small land mass and a stable population.

And finally, the external forces brought about a shift in the economy of the islands. Whereas the livelihood of the early Hawaiians was obtained directly from the cultivation of the soil or from harvesting the sea (the island staples consisted of fish and *poi*, a product of the taro root), economic success became increasingly dependent on the acquisition of skills which permitted individuals to compete successfully in a capitalistic democracy. The indicators of personal or family attainment and security were now based on the Western standards of financial wealth and private property. Over time, various gauges—personal and family income, personal property and real estate holdings, and bank deposits—indicated that the Hawaiians were below the levels of the Caucasians and even the ethnic groups initially imported as laborers, such as the Chinese, Japanese, and Koreans. The economic and social dislocations became exacerbated during periods of limited resources, limited occupational opportunities, and high costs. The Hawaiians' disproportionate lack of financial success has been explained in terms of an incompatability of cultural values and a competitive money economy. Whatever the reason, the resulting disillusionment, anger, and frustrations were not mitigated when the Hawaiians found it increasingly difficult to own or to live off their native land.

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[7] A.W. Lind, *Hawaii's People*, (Honolulu, The University Press of Hawaii, 1980).

Cultural Revival

Within the last two decades, however, there have been positive changes in the milieu in which the Hawaiians find themselves. These transformations have resulted in the uplifting of the Hawaiian psyche and a strengthening of their role in the societal structure. Following the lead of activists in other minority groups, champions of the Hawaiian cause undertook actions on a number of different fronts including education, politics, and land utilization—designed to advance the status of their people. Although there was dissension among the people themselves regarding certain activities and methods, there was agreement that the preservation of the culture was preeminent, and spiritual guidance and the counsel of elders infused all undertakings.

Alu Like, "working together," was incorporated in 1975. One of the first tasks of this organization was to conduct a needs assessment of the Hawaiian people, and, as a consequence, several programs were developed to meet high priority areas, particularly for the disadvantaged. In 1976 the *Hokule'a*, a double-hulled canoe which was designed and built to be true to the ancient Hawaiian vessel, completed the trip from Hawaii to Tahiti and back again. Perhaps more than any other single event, the *Hokule'a's* voyage galvanized a resurgence of cultural pride and identity. The interest in all things Hawaiian—music, dance, language, and crafts—was not limited to the Hawaiians, and, moreover, it was often the ancient chants, hula, and practices which were among the most popular among all members of the island community. The Office of Hawaiian Affairs (OHA) was created by the 1978 Constitutional Convention and through enabling legislation passed the following year by the State Legislature. Nine OHA trustees were elected by the Hawaiian people in the 1980 State general election and they will serve to work for the betterment of both Hawaiians (anyone with native blood) and native Hawaiians (individuals with at least 50 percent native blood) through programs organized around economic development, culture, education, land and natural resources, and health and human resources.

Changes in demography cannot be ignored in the evolving status of the Hawaiians. When the native people dominated the islands, their practices and beliefs prevailed. When their numbers shrank precipitously, there were fears that the Hawaiian people and their culture could not survive the impact of increasing numbers of Westerners and Asians to their shores. What was ignored were the strengths of the Hawaiians as a viable reactive, as well as, receptive group. They not only were changed by their contacts with non-Polynesians, but, in turn, had a great impact on the people they encountered. The size of the population with Hawaiian ancestry has increased through the years as a result of intermarriage (see Part-Hawaiian data in Table I). Individuals holding membership in this group run the gamut from those whose understanding of their cultural heritage is scant to those who are more zealous and knowledgeable of their

Photo Frank R. Rotelmo

Photo Frank R. Rotelmo

TABLE I
POPULATION IN HAWAII BY ETHNICITY, 1853-1978*

	1853		*1872*		*1890*		*1910*		*1930*		*1950*		*1970***		*1978***	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Hawaiians	70,036	95.8	49,044	86.2	34,436	38.2	26,041	13.6	22,636	6.1	12,245	2.5	7,697	1.0	8,526	1.0
Part-Hawaiians	983	1.3	2,487	4.4	6,186	6.9	12,506	6.5	28,224	7.7	73,845	14.8	125,224	16.2	161,475	18.7
Caucasian	1,687	2.3	2,944	5.2	18,939	21.0	39,158	20.4	73,702	20.0	114,793	23.0	255,437	33.0	226,180	26.2
Chinese	364	0.5	2,038	3.6	16,752	18.6	21,674	11.3	27,179	7.4	32,376	6.5	29,966	4.0	35,939	4.2
Japanese					12,610	14.0	79,675	41.5	139,631	37.9	184,598	36.9	207,379	26.8	216,964	25.2
Korean							4,533	2.4	6,461	1.8	7,030	1.4	7,201	0.9	9,633	1.1
Filipino	5						2,361	1.2	63,052	17.1	61,062	12.2	61,240	8.0	83,862	9.7
Puerto Rican							4,890	2.5	6,671	1.8	9,551	1.9	4,110	0.5	5,499	0.6
Samoan													5,848	0.8	8,034	0.9
Blacks							696	0.4	563	0.2	2,651	0.5	5,925	0.8	9,078	1.1
All Other	62	0.1	384	0.7	1,067	1.2	376	0.2	217	0.1	1,618	0.3	63,607	8.2	96,925	11.2
Total	73,137	100	56,897	100	89,990	100	191,909	100	368,336	100	499,769	100	773,631	100	862,085	100

* Data for 1852-1970 from A Lind: *Hawaii's People*. Honolulu. The University of Hawaii Press, 1980.
**Data for 1978 from State of Hawaii: *Data Book*. Honolulu, Department of Planning and Economic Development, 1979.
1970-1978 data from Hawaii Health Surveillance Program and excludes persons in institutions or military barracks.

Hawaiianess than their parents. Whatever the case, the Hawaiian influence is visible in these neo-Hawaiians, as it is throughout all aspects of Hawaiian society today, and it has also shaped the lifestyles of members of the other ethnic groups.

The Elderly Hawaiians in Contemporary Hawaii

Longevity and Health

There were close to 6,000 Hawaiians and Part-Hawaiians 65 and over in Hawaii in 1979, and they constituted 8.2 percent of the state's elderly population (see Table II). With only 3.3 percent of its members classified as senior citizens, Hawaiians/Part-Hawaiians have the smallest percentage of elderly members among the major ethnic groups in Hawaii (see Table II). This proportion is less than one-third the national percentage (11 percent) of older individuals in the population. Life expectancy at birth has increased through the years for all ethnic groups (see Table III), and the range, or difference, between the longest and shortest life expectancy rates per given year, has narrowed. Although life expectancy for Hawaiians/Part-Hawaiians has improved relative to Caucasians, Japanese, and Chinese since the early 1900's, in 1970 the native group still fared poorest with a close to 10-year difference between them and the longest-lived Japanese and a more than four-year difference between them and the Filipinos (whose life expectancy was shorter than the Hawaiians/Part-Hawaiians prior to 1930). Not surprisingly, life expectancy at age 65 is also less for Hawaiians/Part Hawaiians: 12.8 for males and 14.2 for females vs. 17.5 and 18.4 for Japanese males and females, and 16.5 and 17.7 for the Chinese; 14.2 and 17.4 for the Caucasians; and 14.6 and 16.9 for the Filipinos.[8]

Table IV presents the rates and rank for various health indices by ethnicity from 1974-1976. Based on the 11 health conditions selected by Burch (see Table IV), the Hawaiians/Part-Hawaiians had the greatest or next to the greatest prevalence for all indices except for tuberculosis and cerebrovascular disease. The summation of health rankings, from best to poorest, placed the Chinese ethnic group first, followed by the Japanese, Filipino, Caucasian, and Hawaiian/Part-Hawaiian.

Why the Hawaiians/Part-Hawaiians have the shortest life expectancy and fare less well on several comparative health measures than do members of

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[8] C.B. Park et al., "Life Tables by Ethnic Group for Hawaii, 1920-1970," *State of Hawaii: Research and Statistics Report*, No. 26, June 1979.

TABLE II
ESTIMATED ELDERLY POPULATION IN HAWAII BY ETHNICITY, 1979*

	*Number of Persons 65 Years and Older***	*Percent of Own Ethnic Group*	*Percent of Total Elderly Population*
Caucasian	17,237	6.6	24.2
Chinese	6,611	12.8	9.2
Filipino	11,024	8.8	15.4
Hawaiian	5,855	3.3	8.2
Japanese	27,096	11.2	37.9
Korean	1,892	10.0	2.6
Black	165	1.3	.2
Samoan	346	2.4	.4
Other	1,261	8.3	1.8
Total	71,487		100

*From Hawaii State Department of Health: Health Surveillance Program, Special Tabulation. Honolulu, Hawaii: Department of Health, 1980a.

**Includes individuals in institutions and military barracks.

other ethnic groups in Hawaii has not been definitively established. Genetic and environmental factors may both play influential roles. There is some evidence to indicate that the status of the Hawaiians/Part-Hawaiians in the areas of income, education, and occupation is not as conducive to longevity and good health as it could be. In terms of personal income (including salaries, wages, dividends, public assistance, and other payments to individuals), they are over-represented (31.2 percent vs. 26.7 percent) in the under $4,000 category and underrepresented (2.2 percent vs. 4.4 percent) in the $25,000 and over bracket compared to the total state population.[9] Older Hawaiians/Part-Hawaiians who are 60 and over also exceed the state proportions of individuals in the poorest half of six categories of family income—under $5,000 up to $14,000—and have less than the state proportions in the richest three groups—$15,000 to $25,000 and over.[10] Hawaiians/Part-Hawaiians tend to have less formal education than other residents. Only 22 percent of adults have any post-high school education compared to 38.5 percent for the total adult state population; the comparable figures for those 55 years and over are 9.8 percent for Hawaiians/Part-Hawaiians and 17.9 percent for the state population. Throughout adulthood Hawaiians/Part-Hawaiians also have a lower ratio of their members in the professional, technical, and managerial category and are overly represented in structural (construction and building) work.[11]

Photo Carol Severance

There is also evidence to indicate that the health practices of the Hawaiians/Part-Hawaiians contribute negatively to their well being.

Nutritional habits, exposure to hazards and accidents, preventive health practices, and lifestyle are affected to a great degree by ethnicity, income, education, and occupation. These variables also interact with genetic factors, and with one another, to influence life expectancy and health status.

Elderly and Families

The continuation of the traditional Polynesian concept of family consciousness can be found in contemporary Hawai'i. At one level, for example, whereas only 1.2 percent of households nationwide were characterized in 1978 as the "doubling up" type of multigenerational household,[12] 17.4 percent of the Hawaiian/Part-Hawaiian group were living in extended families.[13] The average size of families in Hawaii which include persons 55 or older is 3.09; among Hawaiians/Part-Hawaiians the mean is 3.52.[14] In addition, among the various ethnic groups, only Samoan headed families have a larger average number of children (2.8) under 18 years of age than do the Hawaiian/Part-Hawaiian families with their 1.8 children.[15]

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[9] Alu Like. *Native Hawaiian Profile.* (Honolulu. Alu Like, Inc. 1975)

[10] Hawaii State Department of Health. *Health Surveillance Program. Special Tabulation.* (Honolulu. Department of Health, 1980b)

[11] Alu Like. *Native Hawaiian Profile, op cit.*

[12] C. Mindel. "Multigenerational Family Household: Recent Trends and Implications for the Future." *Gerontologist,* Vol. 19, No. 5, 1979, pp. 456–463.

[13] C. T. Hayashida. "The Family as an Alternative to the Long-Term Institutional Care of the Elderly: How Viable Is It?" Paper presented at the Committee for the Humanities Conference, Honolulu, Nov., 1980.

[14] Alu Like. *Native Hawaiian Profile, op cit.*

[15] Hawaii State Department of Health. Health Surveillance Program. Special Tabulation. (Honolulu. Department of Health, 1980 c.)

Photo Rodney [illegible]

TABLE III
ESTIMATED LIFE EXPECTANCY AT BIRTH BY ETHNICITY, 1910–1970*

	Total	Caucasian	Chinese	Filipino	Hawaiian Part-Hawaiian	Japanese	Other[1]	Range[2]
1910[1]	43.61	52.90	56.36	N/A	30.28	49.09	10.59	26.08
1920	46.91	57.02	54.75	32.95	35.03	51.22	28.95	24.07
1930	54.82	62.39	59.60	49.88	42.92	59.89	35.40	19.47
1940	62.84	64.91	65.05	62.92	52.35	67.46	53.99	15.11
1950	69.63	69.64	69.82	69.74	62.64	72.57	67.63	9.93
1960	72.32	72.78	73.83	71.64	64.94	75.55	62.72	10.61
1970	73.97	73.19	76.10	71.79	67.46	77.30	76.88	9.84
Male	72.03	70.68	74.78	70.21	65.05	75.71	75.25	10.66
Female	76.37	76.04	77.60	75.54	69.91	78.93	78.39	9.02

*From RW Gardner, "Ethnic Differentials in Mortality in Hawaii, 1920-1970," *Haw. Med. J.* September, 1980, Vo. 39, pp. 221-226.
N/A = Not available
[1] The 1910 tables for all ethnicities and the "Other" tables for all years should be viewed skeptically.
[2] Highest minus lowest expectancy; excludes "Other."

TABLE IV
RATES AND RANK FOR VARIOUS HEALTH INDICES BY ETHNICITY
HAWAII, 1974-1976*

Condition	Total	Caucasian	Chinese	Filipino	Hawaiian Part-Hawaiian	Japanese	Other
One or More Chronic Conditions	361.2	408.9†(5)§	310.0(1)	310.9(2)	374.9(4)	346.5(3)	679.5
One or More Bed Days	66.0	81.0(4)	51.1(2)	59.5(3)	82.7(5)	45.6(1)	70.8
One or More Hospital Nights	66.3	82.1(5)	47.3(1)	65.4(3)	73.0(4)	49.1(2)	68.3
Back Impairment	34.3	38.8(4)	24.9(1)	31.8(3)	43.0(5)	28.7(2)	35.7
Visual Impairment	10.1	13.2(5)	5.9(1)	8.1(3)	12.5(4)	8.0(2)	11.9
Arthritis/Rheumatism	25.2	39.4(5)	21.3(3)	19.5(1)	27.7(4)	16.9(2)	26.6
Diabetes	22.7	14.0(1)	24.0(3)	20.2(2)	33.7(5)	25.4(4)	27.0
Tuberculosis	2.5	1.6(2)	0.0(1)	7.2(5)	2.0(3)	2.1(4)	2.6
Heart Disease	17.0	19.9(5)	14.7(2)	16.0(3)	19.7(4)	13.9(1)	21.1
Hypertension	56.9	49.0(1)	57.9(3)	55.7(2)	71.8(5)	58.2(4)	57.4
Cerebrovascular Disease	2.9	2.9(3.5)	5.2(5)	2.6(2)	2.9(3.5)	2.5(1)	3.4
TOTAL RANKS		(40.5)	(23)	(29)	(46.5)	(26)	

*From T/A Burch: "Ethnicity and Health in Hawaii." *State of Hawaii: Research and Statistics Report*, April, 1978, No. 23.
†Rate per 1,000 population.
§Rank, with 1 = lowest incidence and 5 = highest incidence.

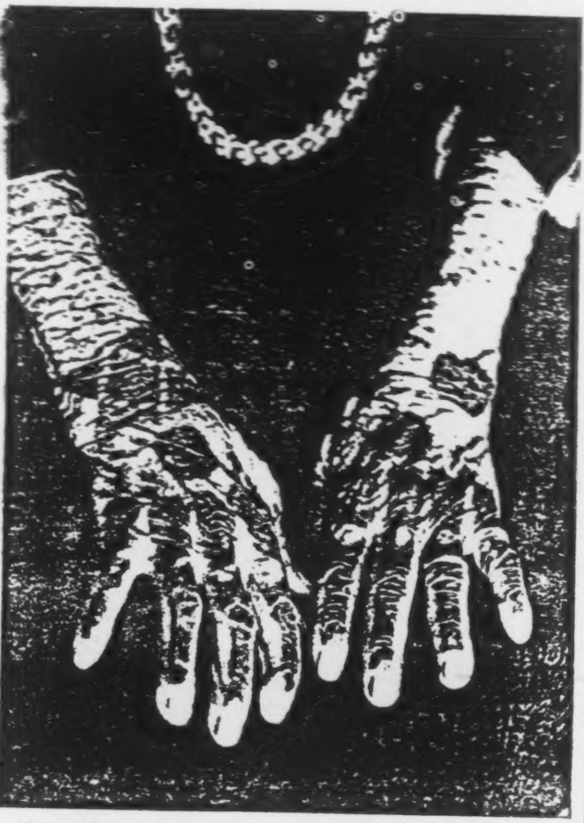

Photo Rene Nakama

About 400 years ago a beautiful princess, while on an annual pilgrimage to Kudaka Island, was caught in a storm and landed north of Okinawa.

The chief Lord of the island was very impressed by the princess's beauty and pursuaded her to remain. The princess was homesick but an official from Okinawa who arrived on the island for diplomatic negotiation urged her not to anger or offend the powerful Lord. However, the two conspired a plot.

The princess tattooed the backs of her hands and then requested an audience with the Lord. The Lord viewed the tattooed hands with horror and disbelief. Later, he gave her permission to return to Okinawa.

After the princess's return to Okinawa, other ladies of the Shuri Court imitated the princess and tattooed the backs of their hands. The ladies felt the tattoos protected them from harm. Okinawan ladies tattooed their hands with designs related to their social status and home areas. Today only a few Okinawan women with tattooed hands remain in Hawaii.

On another level, case histories[16] indicate that many Hawaiians/Part-Hawaiians report dreams, visions, or experiences with portents, generally involving deceased blood relatives. Visions of grandparent or grandchild are reported slightly more frequently than visions of parents or child. These experiences are in keeping with the traditionally close relationships with the *aumākua*, or ancestor gods, and the adoption practice of *hānai*. With regard to the latter, although the first-born child is no longer given routinely to grandparents, the emotions associated with the *hiapo* still exist, and grandparents often feel strongly possessive of *hiapo* grandchildren. The concept of the *hānau mua*, or acknowledged senior head of the family, continues to permeate family life and to shape family decisions. All of this is not to say that the *'ohana* family system has remained intact and is free of problems. Today the term *'ohana* refers both to the extended, as well as to the nuclear family. And although many may cherish the notion of *'ohana* in the traditional sense, the practices that helped the *'ohana* function smoothly—the obligation to forgive and release *(mihi* and *kala)* when asked, conducting *ho'oponopono*, the family conference in which relationships were "set right" through prayer, discussion, confession, repentance, and mutual restitution and forgiveness; and observing the *ho'omalu*, or period of silence to allow tempers to cool and thinking to become rational[17] —may not be observed. These practices, however, are necessary to the preservation of the family system as structured by the early Hawaiians. Conflicts also arise between parents and grandparents regarding the placement, care, and socialization of the *hiapo*. And all *kūpuna* may not be as wise, knowledgeable, or perfect as others, particularly members of younger generations, may romanticize them to be.

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[16] Pukui, *Look to the Source*, op. cit.

[17] Ibid.

Kūpuna as Cultural Resources

The search for ethnic identity and revival of the Hawaiian culture have highlighted the contribution the aged can make in serving as the *kumu*, or source of knowledge. Several programs in Hawaii have been developed to capitalize on this resource. The Friends of Waipahu Cultural Garden Park are working on the creation of a Plantation Village which will serve as a "living museum." When completed, the Village will include both restored original buildings and replicas of the early plantation buildings and will be as faithful to Hawaiian plantation life as Williamsburg is to colonial life. It will include specific areas devoted to each of the various ethnic groups who worked on the plantations and will feature ethnobotanical gardens as well. Unknown to many people, the native Hawaiians brought the original sugar cane to the islands and were the first workers on the plantations. The experiences of elderly Hawaiians who are familiar with plantation life have been recorded on videotapes, and others have been used in research projects, educating visiting children and adults, and restoring artifacts.

Photo: Frank B. [illegible]

In 1978 an amendment to the Hawaii constitution was passed by the Constitutional Convention, and ratified by the electorate, calling for the state to promote the study of the Hawaiian culture, history, and language. The amendment included the phrase, "the use of community expertise will be encouraged." The Queen *Lili'uokalani* Children's Center initiated a pilot project using *kūpuna* to teach young children in educational settings in the areas identified by the constitutional amendment. The Center presently utilizes *kūpuna* with a range of people and in a variety of settings. Knowledgeable elders are used to teach the native language to adults and children; gardening to families; cultural concepts to intermediate and high school dropouts; culture, arts, and crafts to youths in high schools, the correctional facility, and summer programs; and oceanography, agricultural concepts, and culture to adults.

In 1980 when funds were provided to the state Department of Education (DOE) as part of their supplemental budget, the pilot culture, history, and language project mandated by the constitutional amendment was continued by the DOE. The Hawaiian Studies Program, as it is now called, operates with a budget of nearly $300,000. Approximately 33 *kūpuna* are employed for no more than 17 hours per week as part-time teachers to serve in 33 schools throughout the state. Criteria for selection are: *kūpuna* must be from the community in which they will be working; native speakers of the Hawaiian language; knowledgeable through living of the Hawaiian culture (therefore, generally 50 years of age and older); in good physical condition; and able to travel. The part-time teachers move through a training plan which includes: an orientation phase (on the school, program, and prepared teaching units); an observation/participation phase (preparing and presenting cultural lessons); and a practice teaching phase. The *kūpuna* generally teach elementary school children, meeting each of their eight to nine classes three times weekly, with 30 minutes devoted to each class period. The regular teachers then reinforce the teachings of the *kūpuna* through related lessons and concepts.

In 1980 *Alu Like* assisted in planning the first statewide gathering of Hawaiian elderly, *Ka Leo Ō Nā Kūpuna*: the voice of the *Kūpuna*. The purpose of the conference was to address major problems within the Hawaiian family and community, as well as problems facing the Hawaiian heritage, and to seek the advice and counsel of the *kūpuna* in achieving solutions. Riding on the crest of the enthusiasm and interest generated by the conference, the *O'ahu* delegation of elders with the assistance from the *Alu Like O'ahu* Island Center formed a non-profit group, *Ka Leo Mana O Nā Kūpuna*—the powerful voice of the *kūpuna*. The goal of this group is to promote the Hawaiian language and culture and to act as consultants and resource people.

The change from a traditional to a modern society has not been without pain for elderly Hawaiians. They can ease the transition for future generations when they, and the aged of other ethnic groups, share with us not only the legacies of their traditional past, but also their strengths in coping with an evolving social and cultural system.

Senator MATSUNAGA. Our next panel of witnesses is here to discuss proposed changes to Title VI of the Older Americans Act which established a program of grants to Indian tribes to provide services to elderly Indians. I am pleased to welcome my distinguished colleague from New Mexico, Senator Bingaman, to lead the panel. Joining Senator Bingaman are Mrs. Mae Chee Castillo, a Navaho elder, who has been honored for her heroism in rescuing a bus load of preschool children from a flood; the Honorable James Hena, Governor of the Pueblo of Tesuque Tribe; and Mr. Steve Wilson, Manager of the Community Research and Development Administration of the Creek Nation; and Mr. Kenneth White, a program specialist with the National Indian Council on Aging.

Joining Mr. White from the National Indian Council on Aging is Mr. Curtis Cook, the executive director of the council. I would also like to welcome Mrs. Largo who will be acting as interpreter for Mrs. Castillo. Senator Bingaman, we would be pleased to hear from you first.

STATEMENTS OF HON. JEFF BINGAMAN, A U.S. SENATOR FROM NEW MEXICO; MAE CHEE CASTILLO, PUEBLO PINTADO, NM, ACCOMPANIED BY LARGO, INTERPRETER; HON. JAMES HENA, GOVERNOR, PUEBLO OF TESUQUE, SANTA FE, NM; STEVE WILSON, MANAGER, COMMUNITY RESEARCH AND DEVELOPMENT ADMINISTRATION, CREEK NATION, OKMULGEE, OK; AND KENNETH WHITE, NATIONAL INDIAN COUNCIL ON AGING, ALBUQUERQUE, NM, ACCOMPANIED BY CURTIS COOK, EXECUTIVE DIRECTOR OF THE NATIONAL INDIAN COUNCIL ON AGING

Senator BINGAMAN. Thank you very much, Mr. Chairman. Senator Matsunaga, we thank you very much for holding this hearing and for permitting all of us to testify. I appreciate particularly the opportunity you have provided to hold a hearing on the issue of minority concerns. In New Mexico, as you know, we have a very large Hispanic and American Indian elderly population. Older Indians, in particular, are among our country's most impoverished citizens. I am sure some of the testimony you will hear from this panel will confirm that statement. Inadequate and inaccessible health care, lack of transportation, dilapidated housing, and a high rate of poverty is the common environment in which many of these elders live. In order to open up greater access of services to older Indians, I introduced yesterday, the Older American Indian Services Improvement Act, S. 1069, which amends the Older Americans Act.

I am pleased that joining me as original cosponsors are Senators Nickles, McCain and Domenici. S. 1069 attempts to strengthen the current Indian grant program under Title VI, and to increase coordination between Title VI and other portions of the Older Americans Act, in particular, Title III state grants and Title V employment services.

Through these new provisions older Indians would be eligible for Title III services and they would gain an Indian contractor to provide employment opportunities to them. Title VI has been underfunded since its inception, and these changes would allow greater access to more permanent programs.

I have a more detailed statement, Mr. Chairman, that I would like to insert in the record, if I am permitted to do so.

Senator **Matsunaga**. Your statement will appear in the record as though presented in full.

Senator **Bingaman**. Thank you very much.

[The prepared statement of Senator Bingaman follows:]

STATEMENT OF SENATOR JEFF BINGAMAN
SUBCOMMITTEE ON AGING OF THE COMMITTEE ON LABOR
OLDER AMERICAN INDIAN SERVICES IMPROVEMENT ACT
APRIL 23, 1987

Mr. Chairman, thank you for holding this hearing today. I appreciate the opportunity you have provided to hold a hearing on the issues of minority concerns. In New Mexico we have a large population of Hispanic and American Indian Elderly. Older Indians in particular ar among our country's most impoverished citizens. Inadequate and inaccessible health care, lack of transportation, dilapidated housing, and a high rate of poverty is the common environment that these elders live in.

In order to open up greater access of services to older Indians, I introduced yesterday the "Older American Indian Services Improvement Act" S. 1069. It amends the Older Americans Act. I am pleased that joining me as original cosponsors are Senators Nickles, McCain, and Domenici.

This legislation attempts to strengthen the current Indian grant program under Title 6 and to increase coordination between Title 6 and other portions of the Older Americans Act. In particular, Title 3 - State grants and Title 5 - employment services. This would mean that old Indians would be eligible for Title 3 services and that they would have and Indian contractor to provide employment opportunities. Title 6 has been underfunded since its inception and this would allow greater access to more prominent program.

Mr. Chairman, this legislation does not create a new program. Rather, it strengthens, expands, and clarifies pertinent titles of the Older Americans Act to ensure better access and delivery of services for older American Indians.

The Subcommittee on Aging during the last reauthorization of the Older Americans Act directed in report language that it join with the Special Committee on Aging to hold oversight hearings on Title VI, the Indian Grant program under the Older Americans Act. Through testimony developed at two hearings sponsored by the Special Committee on Aging, one on the health concerns of Indian elderly, and a second, on the delivery of Title VI services, a substantial record has been laid to justify this legislation being introduced today. For greater detail I recommend that staff look to these two committee prints.

These two hearings confirm that older American Indians remain among our country's most impoverished citizens. They live at a rate of poverty between 33 percent to as high as 83 percent, varying from reservation to reservation. Inadequate and inaccessible health care, lack of transportation, dilapidated housing, and the rural environment of the majority of older reservation Indians add to an already difficult way of life.

Title VI of the Older Americans Act was added in 1978 as a way of delivering services to the American Indian population, but it did not get underway until 1980. Since that time it has grown from 85 to 124 grantees. What has become increasingly evident is the lack of coordination with other sections of the Act, inattention to Indian grantees by the Office of State and Tribal programs, and ambiguity about tribal eligibility for other titles in the Older Americans Act.

Mr. Chairman, I will briefly describe how my bill amends the Older Americans Act to address some of these issues. When Title VI was enacted it did not lay out a statement of purpose nor findings of fact, nor any overall policy statement. These sections have been added to emphasize Congressional intent and support.

The major addition to Title VI is the creation of an Office of Tribal Programs which will administer and oversee the Title VI program. Currently, that program comes under the Office of State and Tribal Programs. This legislation merely separates out an Indian office and designates an Associate Commissioner on Indian Aging -- an "Indian desk," if you will. I feel very strongly that unless such an office is established improvements to the Title VI program will not take place. I believe we have given the Administration on Aging (AoA) an opportunity to establish this office and to make corrections on their own and it has yet to do so. During the last reauthorization of the Older Americans Act, I agreed to withdraw my "Indian desk" amendment on the assurance by AoA that it would create such a position with advice and support from Indian tribes. Much to my dismay this did not happen as agreed. For this reason, I believe that Congress should designate an office to assure greater accountability from AoA to the Indian grantees.

Title VI is further amended to specify that the Associate Commissioner on Indian Aging also establish an interagency task force on older American Indians and produce a study of the availability and quality of services for older American Indians.

One of the major roadblocks for Indians in gaining access to services under the Older Americans Act is the lack of coordination between Title III, State Grants, and Title VI, Indian Grants. With the Indian population fairly evenly divided -- 52 percent living on the reservation and 48 percent in urban areas -- service providers need to know who are eligible. Therefore, this bill deletes the condition that Title VI grantees are not to serve persons eligible for Title III services. I can understand the original intent of this language -- to avoid "double dipping". As was brought out very clearly in a Special Committee on Aging hearing held by Senator Nickles, and echoed at the hearing I chaired on health issues facing older Indians, greater coordination needs to take place between Title III and Title VI. Therefore, opening up access to Title III allows equity for those off the reservation who may be eligible for such services.

To further ensure increased coordination a new section is added to Title III to clarify and require improved monitoring of services between these two titles. Additions include specifying that Indian elders will not be denied Title III services, and that area agencies on aging with a significant Indian population shall conduct outreach activities to identify older American Indians living within their planning and service area. Further, the newly designated Associate Commissioner on Indian Aging shall have some oversight to recommend to the Commissioner the delivery of services and coordination between Title III and Title VI.

Because older American Indians suffer from chronic unemployment, this legislation also calls for targeting of employment services to older Indians under Title V, Community Service Employment. A recent survey conducted by the National Indian Council on Aging shows that only 1.6 percent of the total positions available by the national contractors and state agencies on aging were filled by older Indians. Older American Indians have the lowest rate among all ethnic groups to access employment services under Title V. This bill mandates that at the next available opportunity for national grants or contracts, that older American Indians be emphasized.

This legislation also amends Title IV, Training and Research, to open up grants and contracts to agencies and organizations representing minorities. Adequate in-service training and instruction on the particular needs of older Americans of ethnic backgrounds remains a priority that will hopefully be addressed by a more equitable distribution of Title IV funding.

The bill provides for an increase in authorization that will bring the funding back to its 1984 levels. In 1984, 43 new Title VI grantees were added to the previous 83 grantees. This accounted for drastic reductions that on average amounted to $20,000 for each previously funded grantee, however, in my state of New Mexico some Title VI programs experienced 70 percent reductions and one Title VI grantee had to discontinue its program. Because of the inadequate funding levels for Title VI, these programs have not been able to provide services commensurate to Title III. I am hopeful with this increased authorization that the quality of service will improve and that more older Indians will be served.

Mr. Chairman, with the strong support of its distinguished House sponsors and the support of my colleagues in the Senate, I am hopeful that this legislation will be incorporated into the overall reauthorization bill of the Older Americans Act. I look forward to working with my colleague from Hawaii, Mr. Matsunaga, and thank him for holding hearings this Thursday on the problems of older American Indians and other minority groups.

I look forward to hearing from your panel of witnesses today, including Mae Chee Castillo, a Navajo grandmother from Pueble Pintada, New Mexico. Mae received, well-deserved public recognition two years ago when she visited President Reagan for heroism in rescuing 10 pre-school children from a burning school bus. Mae had the courage to express to the president the concerns of older Indians. She subsequently was recognized by Ms. Magazine and was inducted as a member of the New Mexico Women's Hall of Fame. I am especially pleased and honored to have Mae Chee Castillo here. Her remarks will be interpreted since she is fluent only in Navajo. Also here on this distinguished panel is Governor James Hena from the Pueblo of Tesuque which is outside of Santa Fe, New Mexico. Governor Hena has been a strong advocate for the older Indians in New Mexico and is an articulate spokesperson.

I again thank you Senator Matsunaga, for your leadership in reauthorizing the Older American Act.

Senator BINGAMAN. I would like next to introduce the distinguished panel of witnesses that have come today to address Indian elderly issues.

The first witness is Mae Chee Castillo, a Navajo grandmother from Pueblo Pintado, New Mexico. As you mentioned in your statement, Mrs. Castillo received notoriety two years ago when she was recognized by President Reagan for her heroism in rescuing ten preschool children from a burning school bus. Mae, at that time, had the courage to express to the President the concerns of older Indians.

She subsequently was inducted as a member of the New Mexico Women's Hall of Fame, and I am especially pleased and honored to have her here today, and her remarks, of course, are going to be interpreted since she is fluent only in Navajo.

Also on this distinguished panel is Governor James Hena from the Pueblo of Tesuque which is right outside Santa Fe, New Mexico. Governor Hena has been a strong advocate for older Indians in New Mexico and throughout the country and is a very articulate spokesperson. He also serves as the Vice-Chairman of the Board of Directors of the National Indian Council on Aging.

Your third witness that I would like to recognize is Ken White, who is Navajo, and who will be representing the National Indian Council on Aging (NICOA). Ken, although young in years himself, has made it his profession to work in the field of gerontology, and in particular, study the problems of older Indians. I would also like to recognize Curtis Cook, who is accompanying Ken on this panel. Curtis is the executive director of NICOA and has worked tirelessly to bring about legislation for older Indians.

And the final witness today on this panel is Steve Wilson from the Creek Nation. Steve is the current chair of the organization of Title VI grantees and serves on the National Indian Policy Committee that has pushed for changes in the Older Americans Act.

Unfortunately, Mr. Chairman, as you know, I am involved in the mark-up of the defense authorization bill in the Armed Services Committee, and will be unable to stay and hear this panel. But I am certain the committee will hear excellent testimony and will come away with an understanding of the issues that my legislation attempts to address.

Again, I appreciate your leadership in bringing about the reauthorization of the Older Americans Act.

Senator MATSUNAGA. Thank you, Senator Bingaman, for taking time out of your busy day to come to this hearing. We certainly appreciate it, and I am sure that your constituents do appreciate it also.

Senator BINGAMAN. Thank you, Mr. Chairman. I will excuse myself if possible and allow you to go on with the witnesses.

Senator MATSUNAGA. All right. Then we shall hear from Mrs. Castillo.

Mrs. CASTILLO. Good afternoon, Honorable Chairman and committee members. My name is Mae Chee Castillo. I am a member of the Navaho tribe. I am from Pueblo Pinata, New Mexico. I come before you today to simply ask your help for the Native American elders of our country. I feel that housing for the elderly is the number one priority. When we get housing, it does not include water, electricity and heating. Sometimes when the elderly receiving housing assistance, it is not adequate because of no water, electricity and heating system. This leads to poor health and poor nutrition. To give you an example, we cannot drink milk or eat fresh vegetables because there is no electricity to refrigerate these items.

The second thing is that road and transportation is another issue that must be addressed. Many roads on the reservation are not paved. It is impossible to travel on these roads when there is bad weather. This causes the elderly to miss a lot of hot meals at the Senior Center Meal Program. If there is an emergency, one must travel approximately 20 to 30 miles to receive adequate hospital care or just to get groceries from the store.

A third issue is that when I receive my food stamps, I only get $10 per month, and I think most of the elderly $10 is about all they receive. And this is not enough. And I am really concerned about that. To be in good health, we need more than $10. I am here today, and one of our meals cost $12, and the food stamps are only $10. It is not enough.

Indian elders are very educated in their own ways. They want to be able to share and educate the young generation in their cultures and their traditions. Indian elders can provide this knowledge through the various senior citizen programs. Please consider more funding to employ the Indian elderly to provide these educational services.

My children support the Indian elders through a National Indian Aging Policy and the Older Americans Service Improvement Act, Senate Bill 1069. I pray that someone here today will hear my plea. I am getting old and my health is poor. Elderly like myself cannot wait five years for help. Please do not forget our needs and our desire to live in dignity.

Thank you very much and have a nice day.

Senator MATSUNAGA. Let me assure you that your voice has been heard and will continue to be heard through the printed page.

[The prepared statement of Mrs. Castillo follows:]

STATEMENT OF MAE CHEE CASTILLO
NATIVE AMERICAN ELDER
Pueblo Pintada, New Mexico

Before the

United States Senate Subcommittee on Aging
Committee on Labor and Human Resources

Regarding

The Reauthorization
of the Older Americans Act

April 23, 1987

Washington,D.C.

Good Morning, Honorable Chairman and Committee Members. My name is Mae Chee Castillo, I am a member of the Navajo Tribe from Pueblo Pinata, New Mexico. I come before you today to simply ask your help for Native American elders of our Country. I think one way to help is to develop a National Indian Aging Policy.

I feel that housing for Elderly is the number one priority. When one gets housing, it should include: water, electricity and heat. Often times when an elderly receives housing assistance it is not adequate because of no water, electricity and heating system. Some houses remain half complete because of not enough building materials, such as plumbing, and electrical wiring. This then leads to poor health and poor nutrition. To give you an example, we cannot drink milk or eat fresh vegetables because there is no electricity to refregerate these items.

Roads and Transportation is another issue that must be addressed. Many roads on the reservation are not paved. It is impossible to travel on these roads when there is bad weather. This causes the elderly to miss a hot meal with the Senior Center Meal Program. If there is an emergency, one must travel approximately 20-30 miles to receive adequate hospital care, or to get groceries from the store.

Indian elderies are very educated in their own ways. They want to be able to share and educate the young generation thier culture and traditions. Indian Elder's can provide this knowledge through various senior service programs. Please consider more funding to employ Indian Elders to provide these educational services.

I pray that someone here today will hear my plea. I am getting old my health is bad. Elders like I cannot wait five years for help. Please don't forget our needs and our desire to live in dignity.

My children, support the Indian elders through a National Indian Aging Policy and the Older American Service Improvement Act (Senate Bill 1069). Thank You and have a good day.

SUMMARY OF TESTIMONY
OF
MAE CHEE CASTILLO

Mae Chee Castillo's testimony will be presented from the perspective of one who is, herself, an Indian elder. She gained national notoriety in 1985 when she travelled to Washington, D.C. to receive a special award from the President for her heroism in rescuing a busload of pre-school children from the dangers of a flooded arroyo on the Navajo reservation in Arizona.

Her testimony will cover three major areas:

1. Ms. Castillo speaks on behalf of Indian elders from the Navajo reservation, and her concerns are typical of those shared by Indian elders in all areas of the country (eg., the need for nutrition, housing, transportation and improved social services programs.
2. She was involved in the initial development of a draft National Indian Aging Policy in 1984.
3. Based on that involvement, she is coming to speak in support of the implementation of an appropriate National Indian Aging Policy, and in support of the proposed amendments to the Older Americans Act presented by the Indian aging advocates on the panel.

Since Ms. Castillo is monolingual in Navajo, her remarks will have to be interpreted for the Committee. We have arranged for an interpreter to be present.

Senator MATSUNAGA. We would be delighted now to hear from Governor Hena.

Mr. HENA. Thank you, Mr. Chairman. Good afternoon. My name is James Hena, and I am the Governor of Tesuque Pueblo in New Mexico. I am also the Vice Chairman of the Board of Directors for the National Indian Council on Aging and a member of the task force appointed by Indian senior citizens throughout the country to work on the reauthorization of the Older Americans Act of 1965.

You already have my written testimony so I will just summarize.

Senator MATSUNAGA. Your written testimony will appear in full in the record.

Mr. HENA. Fine, Mr. Chairman.

Senator MATSUNAGA. The testimony of every one of you will appear in the record in full.

Mr. HENA. I just want to place emphasis on the unique government to government relationship that Indian tribes have in this country with the United States Government. I believe this is the basis of the system that was established as a result of the settlement that occurred during the early days of this continent's settlement. There were Indian tribes residing on this continent operating tribal governments and so forth. As a result of that, that were treaties entered into between the United States and Indian governments. And it is that relationship that we continue to enjoy even today. And in this legislation which the good Senator Bingaman from New Mexico introduced, S. 1069, we would like to see that same relationship continue on a government-to-government basis between the U.S. Government and the hundreds of Indian governments in this country.

I think another reason for wanting to continue seeing this is because as Indian tribes we have certain lands where we have jurisdiction over such areas by virtue of the constitutions or sovereign authorities of the tribe that existed when like in our case the Spanish government came and settled in the Southwest. They recognized and dealt with the various Pueblo governments, and in the Treaty of Guadalupe-Hidalgo that was signed between the United States and Mexico in 1846. The United States Government recognized those Indian governments that existed back then, and I think that we can point out that the history within this country that by virtue of the various treaties that was entered into between the U.S. Government and Indian tribes, and in some cases ratified by the Continental Congress, in some cases ratified by the U.S. Congress, and promulgated by executive orders of the White House and supported in some instances by decisions of the United States courts, that we would like to see this relationship continued. Furthermore, some of the reservations, or most of the reservations are located in isolated rural areas, far away from transportation or service agencies.

It is the additional cost that is involved in reaching those services for the elderly that we would like to see some improvements made through S. 1069. There will be others on this panel that will be addressing the various titles that we have talked about and that Senator Bingaman has included in S. 1069. So without further ado, I would just say thank you for letting me speak to this Committee.

Senator **Matsunaga**. Thank you very much, Governor. Your statement will appear in the record in full, of course. If we do have questions we will submit them to you in writing, and you may respond in writing. This goes for all the members of the panel.

[The prepared statement of Mr. Hena follows:]

TESUQUE PUEBLO
ROUTE 11, BOX 1
SANTA FE, NEW MEXICO 87501

TESTIMONY PRESENTED TO THE SENATE

SUBCOMMITTEE ON AGING

April 23, 1987

Good Afternoon! My name is James Hena and I am the Governor of Tesuque Pueblo in New Mexico. I am also the vice-chairman of the Board of Directors for the National Council on Aging and member of the Task Force appointed by Indian senior citizens to work on the re-authorization of the Older Americans Act of 1965 as amended through October 1984.

Mr. Chairman, I wish to express the gratitude of the Indian senior citizens and my personal thank you for allowing us these few minutes to tell you of our needs and concerns which confront and which will continue to confront our local Indian communities and reservations across this land.

I'm sure that others can quote statistics and other data to explain why direct assistance to Indian senior citizens is important and essential. I can tell you from the perspective of my personal observations, conversations and developments that I've watched, or have being a part of, the importance of legislation that will address the needs of Indian senior citizens.

Most of you have heard of the drastic economic conditions that exists today on many Indian reservations, as a result of rural isolation located too distant from cities where services, which are taken for granted in Washington D.C., are located. For example hospitals, nursing homes, doctors, nurses and other health providers. Lack of public transportation and any means for emergency transportation, properly trained first line technicians and so on, are none existent and insufficient. The fact that Indian senior citizens are growing in numbers also adds to the need for direct services. Even Indian veterans of whom we have many among Indian senior citizens ranks, are also deprived of VA Medical services for lack of transportation to medical centers.

OFFICE OF THE GOVERNOR
PHONE 983-2667

While the state in which our reservations are located in may be using Indian population figures to justify or verify need for Federal funds, services which are made available from such funds to non-Indians are not extended to Indian reservations. Or there are strained relations between state officials and tribal officials because of disagreements which impede the services which Indians might be entitled to as State citizens.

For example, my tribe is involved in litigation over surface and sub-surface rights to water against the State of New Mexico, and caught in this same case are about 2,000 non-Indian families whose rights to water are also being challenged by the State. The State Engineer is the lead official for the State in the case and he has challenged my tribe in one sub-case for increasing our water use. Even when the Judge hearing the case has decided that the State has no right to extend its authority onto our lands. More recently, the State Engineer is claiming that a piece of land about 4 acres, set aside for a school is not reservation land so the State can have control over the subsurface water for those acreages. Also, in our State, we have a State Law that authorizes contracts between State agencies and non-State entities. We tried to negotiate a contract to do some erosion control which would have protected a bridge on a public highway through our reservation. Needless to say, we weren't able to reach agreement because the State was unwilling to be flexible.

While the rank and file employees of State Government want to work with us, the attitude it seems, on the part of higher state officialdom is to jar open the door so that the State will have some authority over Indian governments. In these kinds of situations, cooperative arrangements such as for Indian senior citizen services are not provided by State agencies or the cost is prohibitive due to distance, poor roads, etc.

I'm sure that across this land, there are services being provided through State agencies to Indians; however, historically, because of the effort on the part of State Governments to assume jurisdiction over activities within an Indian reservation, most tribes prefer dealing with the Federal Government. Also, because many tribes negotiated treaties with the U.S. Government, there is a legal basis for dealing with the U.S. Government and Indian Tribal Governments. It is on such a basis that Indians would like to work from in implementing programs under the auspices of the bill that you've recently introduced.

Presently, Indians are entitled for services only through Title VI. We would very much like to have the services provided through the various other Titles or aspect of those services incorporated into Title VI. Also, we would like to see an administrative position established to oversee that Indians are getting their fair share of the benefits and services that the legislation may provide for. Most departments have established a special Indian Desk to promote, coordinate and target programs and services for Indians. In so doing, the Indian population is at the least assurred that they will share in benefits directed at the general U.S. population.

In closing, I just want to remind all of us that Indian Nations, Tribes, Pueblos and so on, existed before the establishment of the colonies and later the U.S. Republic, it is the relationship that developed then, that we'd like to see honored and recognized and utilized in working with Indian tribes.

Thank you.

Senator **Matsunaga**. Our next witness is Mr. Steve Wilson. We will be happy to hear from you, Mr. Wilson.

Mr. **Wilson**. Thank you, Senator. I want to thank you and your committee for conducting this hearing. I would like to give my special thank you on behalf of the 135 national Title VI grantees throughout the nation. We have become very concerned about problems in trying to serve our Indian elderly at the levels of funding that we have received. Since the period of funding started in 1980 through the period of 1984, although the funding was at a small level to each of the tribes, we became accustomed to this level, and it became a stability to us. Nutrition programs were running everyday. Certain services such as transportation, home bound meals, chore services, information and referral were being provided by the tribes at this level and at a stable level because we were used to this low amount of funding.

But in 1984, we were notified—I am talking about the 83 original grantees—were notified that we were going to be cut in funding due to the fact that the Administration on Aging was going to fund 42 new grantees. Why did not Congress fund those 42 new grantees? Why did we have to do this? Why did the Administration on Aging decide the policy for us?

This has been our big concern in the last few years we have not had the visible advocate in the Administration on Aging from the Commissioner for our programs. When policies such as this become evident, and it is real to our program, it hurts our programs. We have to cut back services to our elderly. When this happened to us, many tribes had to cut back transportation services. They even had to cut back the number of meals they were going to serve to their elderly.

They even cut back the number of days they served meals. And when the Administration's response to us on why this was done, all they could say it is just an average of 15 meals a day to your program. They did not realize, or maybe they do not care, that this meant that elderly Indian people were being cut back in these services.

When the Commissioner testifies that there is cooperation between the tribes and the state programs and they encourage this, this is initiated by the tribes. In 1984, when we realized that we were not getting support from the Commissioner on our shortcomings in our programs, our organizations, the National Indians network, went on a tour, so to speak, throughout this nation, putting on workshops at national conferences, trying to bring the plight of the Indian elderly to the forefront.

They have become supportive of us, but we cannot get support where it is counting, and that is in the Administration on Aging. We do need an Indian Desk. We need somebody in the Administration that knows our governments, that knows our Indian people that will not make policies that are going to hurt our programs. When we went into the area of developing an Indian aging policy, many of the areas that need to be remedied in the Indian aging, and you heard it in housing, all the programs that have come down through the pike for Indian programs is not reaching everybody.

There is not targeted elderly programs for elderly people for transportation, housing, Indian health service, Bureau of Indian

Affairs. All these services are not targeted, they are not saying to the Indian elderly we are going to target you. This is what the policy that we have drafted and approved by the National Indian Council on Aging, by the National Title VI Association. We have taken this policy and we have drafted portions of that policy into a law with the support of Senator Bingaman. That is what was introduced for us.

If all that is in the bill is accepted, and we urge the support of it, this will alleviate some of the problems. We had to come to agreement on the funding level. In my testimony that you have for 1988, we had asked and agreed for 18 million. We had to compromise on the levels of funding in the bill, hopeful that Title V, senior employment, that a National Indian Aging Organization, will receive funding in a national contract that could help our program.

We ask for the Indian Desk because we need policies that are going to help us, not hurt our programs. We ask for coordination of Title III and Title VI that will allow us to receive and enjoy supportive services if our tribes cannot provide those services. Maybe the state can. But once again, we appreciate this opportunity, Senator, and urge support of Senate 1069. Thank you, Senator.

Senator MATSUNAGA. Thank you very much, Mr. Wilson.

[The prepared statement of Mr. Wilson follows:]

Testimony

of

Steve R. Wilson, Manager
Community Research and Development Administration
of the Muscogee (Creek) Nation of Oklahoma

On behalf of

The National Title VI Grantees Association

before the

U.S. Senate Committee on Labor and Human Resources
Sub Committee on Aging

Regarding

Reauthorization of the Older Americans Act

April 23, 1987

TESTIMONY OF THE NATIONAL TITLE VI GRANTEES ASSOCIATION
PRESENTED BY STEVE R. WILSON, CHAIRMAN

Good Afternoon Chairman Matsunaga, Members of the Committee, ladies and gentlemen, to my Indian elders and my colleagues in the Aging Network. I would like to give my special "Thank You" to this committee on behalf of the 135 grantees for conducting this hearing. I hope to enlighten this committee on the concerns we are experiencing in trying to serve our elderly under the Older Americans Act (OAA).

HISTORY OF TITLE VI

Since the enactment of the OAA in 1965, we have seen many changes in types of services available to older citizens of this country. During the 1970's , Indian tribes and organizations felt that the Indian elderly were not receiving equitable services under the Act.

In October, 1978, Congress amended the OAA that resulted in the enactment of Title VI which provided for direct funding to "federally-recognized" Indian tribes. However, funding was not available to the tribes until 1980. Also, we learned immediately that funding was not going to be adequate so tribes would not be able to provide services comparable to the services in the Title III area.

The first year of funding eighty-five (85) tribes were funded; eighty-four (84) tribes were funded the second year; eighty-three (83) tribes were funded the third year. In April, 1985, AOA funded forty-two (42) new Title VI grantees and ten (10) new grantees in September, 1986.

FUNDING LEVELS TO TITLE VI

Individual funding levels to the grantees was a maximum of $100,000 to the larger tribes and was staircased downward from that level depending on the number of elderly in the smaller tribes.

Since 1984, the cuts in funding have deteriorated due to lack of funding from Congress and policies or funding by the Administration on Aging.

For example, funding levels started at $6 million and have even gone downward threatening the figure of less than $5 million that would require assistance in accordance with the provisions of title III. At the present time our funding level is at $7.5 million which still leaves us below original individual grants of $100,000 to the larger tribes and leaving us with many unserved and underserved elderly Indians.

With the funding by AOA in April, 1985 of 42 new tribal grantees, caused a cut-back in funding to the eighty-three (83) original grantees because we took funding cuts to fund the new 42 grantees.

Many title VI grantees were forced to cut services including nutritional meals, transportation and other supportive services they were providing on a limited basis.

Also, qualified personnel were cut back to part-time creating vacancies in the programs because they had to find full-time employment. This has caused instability in the programs because new personnel had to cope with a program that didn't have enough funding to provide adequate services but a demand for supportive services from their elderly.

With the stipulation in the Act that individuals to be served by the tribal organizations will not receive for the year for which application under this title is made, services under title III. This provision in the Act was to prevent duplication of services, but how can a service be duplicated if its not being provided in the first place by tribal grantees? This has caused confusion in the Title III network about who is eligible because a tribe receives title VI.

NATIONAL INDIAN AGING POLICY

Testimony has been given about the origination of such a policy and where we are in finalizing the Policy adopted at the National Indian Conference on Aging in Phoenix, September, 1986.

The committment of the conference attendees and the National Title VI Grantees Association to support this Policy gives us hope that the American Indian Elderly would not be the "forgotten American".

With this Policy in hand, we felt that some of the policy could be iniatiated by the Commissioner on Aging. Since this attempt failed, we followed our alternate initative and that was to go through the legislative route.

LEGISLATION

At the National Indian Council on Aging, September, 1986, a National Task Force was formed to finalize the Policy. (I was also elected Chairman of this group). We have met and at our last meeting in Albuquerque, N.M., in March, 1987, we took the Policy and put much of it into legislative form that we have titled "Older American Indian Services Improvement Act." These are our amendments to the Older Americans Act.

POLICY

These amendments would provide Tribes in policy decisions that affect our programs and services to our elderly. We are recommending that a tribal representative be seated on the Federal Council on Aging.

Also, we need a position within AOA that would and could make recommendations about our programs by a person from a "federally-recognized tribe". We are calling this position an Associate Commissioner on Indian Aging Programs. Too many decisions affecting our programs have hurt them and have deteriorated services to our elderly. We have not been asked about these recommendations in the past. A position created and staffed by an American Indian would give us some hope when changes are made in the future.

COORDINATION OF SERVICES

Services to older Indians under title III should be more accessible. Not only under title III but all titles of the Act.

Under Title V - Senior Employment, we recommend that a National Indian Aging organization be given a national contract to meet the enormous unemployment needs of the older American Indians.

When and if amendments are made to the titles of OAA, language should be implemented to assure that Indian tribes could qualify for these funds for services. For example, we support "In-Home Services for Frail Older Individuals". We need to be included in this very important, innovative service to the older individual.

FUNDING LEVELS

Mr. Chairman, we are sensitive to the budget deficits this country faces because we are Americans also. Many of our elderly were parents, grandfathers and grandmothers of participants in the wars our country were in. However, we become concerned when we see many of our elderly who are unserved and underserved not been able to enjoy services that others are being provided because of the barriers that our Indian elderly face - language, insensitivity and other cultural barriers that do not allow them to participate.

We become concerned and cannot answer our elderly when they read that a GAO Report states that it cost taxpayers over $16 million for the Second Inauguration of the President. This is more than twice the amount of total funding for title VI. This was a one-time event whereas funding of this level to title VI grantees would provide services to thousands of Indian elderly on a daily basis.

Our formula and justification is as follows:

> From 1988 to 1992, an increase of 56 new Title VI grantees per year will be needed just to meet the target figure of 403 eligible tribes (or 80% of the total). At an average of $100,000 per new grantee (the amount needed to conduct even a minimal program providing nutrition and transportation), an increase of $5,600,000 per year is recommended for each of the next five years.

The funding projections, then, would be as follows:

1988	-	$ 18.0 million*	180 grantees
1989	-	$ 23.6 million	235 grantees
1990	-	$ 29.2 million	291 grantees
1991	-	$ 34.8 million	347 grantees
1992	-	$ 40.4 million	403 grantees

* $12.4 million to current Title VI grantees plus $5.6 million for 56 additional grantees - beginning in

CONCLUSION

Mr. Chairman, our concern of minorities participating in the Older Americans Act has taken us on a long road to see that the American Indian Elderly be served under this Act. We are years behind state programs due to lack of adequate funding, loss of personnel who could have planned innovative programs had not funding cuts being forced on their tribes.

We enjoy the flexibilities of Title VI to serve traditional foods to our elderly and to determine the age for services. With adequate funding, coordination of services and policy-making avenues we are recommending in our amendments, we could once again hope for the future and our elderly could enjoy services that are targeted for them.

TESTIMONY ON BEHALF OF THE NATIONAL TITLE VI GRANTEES ASSOCIATION REGARDING THE REAUTHORIZATION OF THE OLDER AMERICANS ACT

PRESENTED BY STEVE R. WILSON

EXECUTIVE SUMMARY

The National Title VI Grantees Association suports the Older Americans Act and its Reauthorization. Without the Title VI Amendments in 1978, services to the older American Indians would be next to non-existence under the Act. We appreciate and thank Congress for Title VI.

The National Title VI Grantees Association opposes the consolidation of funding for OAA programs or as we know them as "block grants". We feel that the identities of these programs and for what they are intended would be lost in the shuffle.

We oppose the proposal to raise the age from 60 to 70 under Sec. 303 due to many minorities who do not reach or live that long a life.

We oppose that no National fee-for-services plan be adopted that is being recommended by others.

We support coordination of services to older American Indians under Title III to other Titles.

We support a National Indian Aging organization be recommended for a contract under Title V - Senior Employment.

We urge support for any long-term care facilities administered by tribal organizations. At the present time there are nine (9) nursing homes with a total of 532 beds.

We urge easier guidelines for tribes and tribal organizations to be designated as Area Agencies on Aging. Currently out of 673 Area Agencies on Aging in the Nation, only nine (9) are Indian.

We urge support of our amendments to the OAA entitled "Older American Indian Services Improvement Act" which would increase participation of older American Indians.

Senator MATSUNAGA. We will be happy to hear from you now, Mr. White.

Mr. WHITE. Mr. Chairman, members of the committee, thank you for the opportunity to express our concerns. We come before you in the context of the unique sovereign relationship of the tribes with the federal government and also come before you as one unified body. There were 64,000 elders in 1970. In 1980, 109,000 elders, and in 1990, 200,000. With this increasing population, there is also an increasing level of need.

Rather than reiterate numerous concerns, I would like to spend my time highlighting specific recommendations. One solution that holds promise for the Indian elderly has been the development of a National Indian Aging Policy. In 1981 former Commissioner on Aging, Dr. Lennie Marie Tolliver, testified and committed AOA to developing a National Indian Aging Policy. She identified 1982 as the deadline. To date no such policy has been developed by the Administration on Aging. Last November 1986, we met with the Administration on Aging to hand carry a proposed policy to the Commissioner. We were informed by the Commissioner that policy development was a legislative issue and could not be supported by AOA.

Perhaps we should not be surprised. Instead of relying on the results of surveys and research, AOA has painted a misleading picture that portrays Indian elders being more than adequately served under the act, by citing deceptive statistics. For example, the Commissioner on Aging testified that under Title VI, of the 28,000 elders, about "90 percent" participated in nutrition service. Surveys of Title VI grantees indicate under 50 percent of the elders are served, not "90 percent."

Even using the Commissioner's figures shows that many Indian elders are undeserved. 90 percent of 28,000 is about 25,000 people. This is only 14.6 percent of today's total Indian elderly population. We appreciate what has been provided, but the real question is do these attempts reach the Indian elders 22 years after the act was originally passed? Our findings document they do not.

Let us not distort the reality that Indian elders are being unserved or underserved. In order to correct inequities we have proposed a number of amendments to the act. We seek to accomplish increased representation, participation and authorization levels. Under Title II, increased representation can be accomplished by identifying an Indian representative on the Federal Council on Aging, by assuring the development of more Indian Area Agencies on Aging, and by establishing an Associate Commissioner on Aging within the Administration on Aging, a position to be filled by a qualified American Indian.

Under Title III, increased participation can be accomplished by allowing for amendments to Title III to clarify that Indian elders not receiving Title VI are eligible for Title III. The law must assure no Indian elder shall be prohibited from receiving services under this title. Under Title IV, research and demonstration grants must continue to be made to the Indian tribes because there are few non-Indian models acceptable in the Indian community.

Under Title V, increased participation of Indian elders in Senior Community Service Projects can be accomplished by more effectively targeting them through a national Title V contract to a national Indian aging organization. At present, because there is no specific focus, Indians occupy only 1.5 percent of more than 79,000 Title V positions.

A national contract could be used to assist existing Title III and Title VI programs presently suffering from limited staff. Under Title VI, increased participation and funding are also very high priorities among Indian tribes. Currently, slightly over one-fourth of the Indian tribes have Title VI grants. These grantees served only 50 percent of the elders. Therefore, essentially one-eighth of the eligible Indian elders are served under Title VI. Fewer elders are served and fewer services are provided than nine years ago.

On the surface, the addition of new grantees would lead the observer to assume that there has been increased minority participation, while in actuality the grantees already in existence are destabilized and experiencing service reductions. Other major concerns that we have is that we wish to make clear that we strongly support the concerns of urban Indian elders.

We strongly recommend that an inter-agency memorandum of agreement between AOA and the Bureau of Indian Affairs and the Indian Health Service to coordinate Indian elderly services be required by the Congress.

We strongly oppose any measures that would require the eligibility of programs under the act to be placed at 70 years of age.

We strongly oppose the consolidation of AOA funds through block grants that would dilute the special relationship tribes have with the federal government. In conclusion, we appeal to you, respected members of the subcommittee. Is it too much to ask that changes be made in a law that will provide the opportunity to meet the basic needs of the inhabitants of our land? For the crippled elder in South Dakota who has to make her way to the outdoor bathroom at night, for the elder Navajo who eats only cereal at the end of each month, for the elder in New Mexico who is 60 miles from a hospital, for the elder who sits in an off-reservation nursing home in loneliness, we hope your answer is that it is not too much to ask.

During this era where it is fashionable to take up causes, we respectfully call upon you to support very special human beings who have real feelings, real needs, and a long history of pride, the Indian elders. We thank you for your concerns, and we respectfully request that the complete written text of our testimony be included in the official record. Thank you.

Senator MATSUNAGA. Without objection, your statement will be included in the record in full. I wish to thank each and every one of you for taking the time to come before this subcommittee, and you can rest assured that your testimony will be considered in full not only by the chairman but by other members of the committee, and not only by the subcommittee, but by the full committee. And you can rest assured that in the reauthorizing the Older Americans Act, your concerns will be given full consideration.

[The prepared statement of Mr. White and additional material supplied for the record follow:]

STATEMENT OF KEN WHITE
Program Specialist

on behalf of the

National Indian Council on Aging, Inc.

Before the

United States Senate Subcommittee on Aging
Committee on Labor and Human Resources

Hearing on the Reauthorization
of the Older Americans Act of 1987

April 23, 1987

Washington, D.C.

Mr. Chairman, and distinguished members of this Committee, on behalf of the National Indian Council on Aging and the more than 175,000 Indian elders we serve, I wish to thank you for this opportunity to express our concerns. I am Ken White, a Navajo from White Cove, Arizona, and I serve as Program Specialist for the National Indian Council on Aging. The concerns we will present to this honorable Committee today emanate from a profound respect for the American Indian elders and an acute awareness of their needs.

We come before you in the context of the unique and sovereign relationship of the tribes with the federal government. We also come before you as one unified body representing Indian tribes, urban Indians, the National Indian Council on Aging, the National Title VI Grantees Association, and the Indian elders to state that we wholeheartedly support the immediate reauthorization of the Older Americans Act.

There were 64,000 Indian elders in 1970. By 1980, their numbers had grown to 109,000, and by 1990 the Indian elders' population is expected to exceed 200,000. Within this increasing population, there is also an increasing level of need. All too many of America's Indian elders must strive to survive in poverty and ill health, oftentimes in remote isolated areas of the country.

Many of them live in poor housing, without the modern conveniences most of us take for granted: electricity, indoor plumbing, running water, and adequate heating systems. Some have been neglected, abused and exploited by society. If you were to journey to one of the 504 federally-recognized Indian tribes, you would see Indian elders who live in poverty at a rate estimated at 61%, experience unemployment rates of up to 90%, and have a life expectancy which is estimated at from 3 to 8 years less than that of the general population.

Rather than to reiterate numerous concerns documented in two previous Congressional hearings held last year, we would like to spend our time highlighting specific recommendations that have been gleaned from previous testimony.

As is often the case on an Indian reservation, solutions to age-old problems are difficult. However, one solution that holds promise for the Indian elder has been the development of a National Indian Aging Policy. In the fall of 1981, former Commissioner on Aging, Dr. Lennie Marie Tolliver, testified before the U.S. Senate Select Committee on Indian Affairs at an oversight hearing on Indian aging. In her statement, she committed AoA to developing a National Indian Aging Policy. She identified the Fall of 1982 as the deadline date for the finalization of this policy. With much hope and anticipation, Indian tribes submitted recommendations to assist the Administration on Aging in the development of this policy. Since 1981, the National Indian Council on Aging, Inc. has held national conferences in 1982, in 1984 and in 1986 to gather input, data, and recommendations for a national policy. However, to date no such policy has been developed or formulated by the Administration on Aging.

Last November 17, 1986, several representatives of the Indian aging network met with the Administration on Aging to hand carry a proposed policy to the Commissioner, and to discuss strategies necessary to allow the Commissioner to be a "visible advocate" as mandated by the Older Americans Act. The representatives were informed by the Commissioner that policy development was a "legislative" issue that could not be supported by AoA. We then concluded that we would have to take our concerns to Congress rather than to AoA.

Our elders had placed their hopes in the Commissioner's verbal assurances that she would discuss with us a strategy for implementing a National Indian Aging Policy, only to have those hopes dashed by the Commissioner's sudden refusal even to discuss the matter with us, based on the premise that it had become a "legislative" issue. Our delegation was turned away in disappointment and embarrassment at some of the patronizing attitudes of certain AoA staff people who were present at the abortive November meeting. We came to the highest aging official of our land, hoping for advice, technical assistance, and a problem-solving discussion, but came away with no good news for our Indian elders whose lives we sought to improve.

Perhaps, we should not have been surprised, for AoA has consistently ignored statistical documentation and recommendations which the Indian aging network has presented over the years. We contend that culturally appropriate and efficacious services cannot be developed apart from such knowledge and findings.

Instead of relying on the legitimate results of surveys and research, AoA has taken the approach of painting a misleading picture that portrays Indian elders being more than adequately served under Titles III and VI of the Act, by citing deceptive statistics, the source of which remains a mystery to this day.

For example, the Commissioner on Aging testified before the House Education and Labor Human Resources Sub-Committee on March 23, 1987, that, under Title VI, "of the eligible population of 28,417, about 90% participated in nutrition services and about 60% received one or more supportive services." However, surveys of Title VI grantees indicate otherwise. Existing grantees serve on an average only 50% of their elders, not 90%. Futhermore, the total number of Indian elders who are "eligible" for Title VI is equal to the total number of Indian elders residing on the reservation or in rural tribal areas. According to the 1980 census, this number exceeded 58,000, and based on 1990 census projections, it is likely to be in excess of 100,000 today. In order for Title VI to be serving 90% of the eligible Indian elders today, there would have to be 90,000 participants. We submit that AoA's statistics on record are both incorrect and misleading.

Using even the Commissioner's figures, shows that many Indian elders are unserved: 90% x 28,417 = 25,575; this is only 24% of the total Indian elderly population in 1980 (109,000), and only 14.6% of today's total Indian elderly population (if we estimate it at 175,000 based on 1990 projected census figures). Secondly, the "60%" receiving one or more supportive services would represent the following numbers: 60% x 28,417 = 17,050; this is only 16% of the total number of Indian elders in the country @ 109,000), or 9.7% of today's total Indian elderly population @ 175,000).

Yes it can be said that AoA provides a limited amount of funds to Title VI, and a yearly training session to Title VI grantees. And yes, it can also be said that a limited amount of funds have been provided for training through one-time-only discretionary funds. We do appreciate what has been provided, but do these attempts to reach the Indian elders succeed in addressing their basic and special needs 22 years after the Act was originally passed? Our statistics and findings document the fact that they do not. For example, to use Title VI as a case in point:

1) Since 1984, when 43 new Title VI grantees were added, the previously existing 83 grantees have experienced funding reductions averaging $20,000 per grantee. The result has been that needed services, formerly provided by these grantees have had to be severely curtailed, and their elders are being underserved.

2) Besides serious reductions in services, currently Title VI grantees are able to serve only 50% of their elders, leaving another 50% unserved (cf. Senate Special Committee on Aging Hearings, June, 1986, Oklahoma City, Oklahoma).

3) Only 25% of the federally-recognized Indian tribes have Title VI grants; therefore, the elders of the remaining 75% of the tribes are also unserved, and are not participating in Title III services to any appreciable degree.

We bring this to the Committee's attention not to discredit the efforts of AoA, but rather to correct any misconceptions which presently distort or obscure the reality that Indian elders, who experience great social and economic need, are being unserved or underserved by the programs of the Older Americans Act.

In order to correct the inequities and inadequacies of the services now being provided under the Older Americans Act, we have proposed a number of amendments to the Act which are to be presented on the floor of both houses of Congress in the form of a separate bill.

Through the proposed amendments, we seek to accomplish increased representation, increased participation and increased authorized levels commensurate with the basic and special needs of Indian elders.

Title II

Under Title II, increased representation can be accomplished by identifying an Indian representative on the Federal Council on Aging, by assuring the development of more Indian Area Agencies on Aging, and by establishing an Associate Commissioner on Indian Aging within the Administration on Aging; a position to be filled by a qualified American Indian.

Title III

Increased participation can be accomplished by allowing for Amendments in Title III to clarify that Indian elders not receiving Title VI services are eligible for Title III services. Coordination of services can be enhanced between Title III and Title VI by assuring:

a) No older American Indian shall be prohibited from receiving services under this title.

b) Each Area Agency on Aging, in order to be approved by the State agency, shall assure that outreach activities designed to identify older American Indians eligible for assistance under this Act, and to inform such Indian individuals as to the availability of such assistance.

c) The Associate Commissioner on Indian Aging shall evaluate the adequacy of services under this title for Indian individuals, and make recommendations to the Commissioner on needed improvements or acceptability of the performance of applicants under this Title.

Title IV

In Title IV, research and demonstration grants must continue to be made to Indian tribes and organizations, since (1) few research projects are developed that address Indian elders' unique needs (2) research is a most powerful tool to use to make changes that will positively impact the quality of life of Indian elders; and (3) there are few "non-Indian" models of care that are sensitive and acceptable in the Indian community at large.

The tie between the Indian aging population and academic institutions allows for professional growth and learning that ultimately result in improved services.

Title V

Increased participation of Indian elders in Title V Senior Community Employment Programs can be accomplished by more effectively targeting them through the awarding of a national Title V contract to a national Indian aging organization. At present, because there is currently no specific focus on Indian elders in the plans of the existing contractors, persons identified as Indian occupy only 1.5% of the more than 80,000 Title V slots in the nation.

It is our belief that levels of participation in such income support programs as Title V should be keyed to the levels of unemployment and poverty experienced by the various targeted populations.

Employment programs are effective in the Indian community.

Our findings indicate that Indian elders seek employment roles rather than welfare and dependency. The work ethic is very much a part of the daily life of the Indian elder, yet there are few opportunities to participate.

The provision of a national Indian contract, similar to those awarded to the National Hispanic and Black minority organizations, would permit Indian elders to become immediately a part of the national aging network. Title V positions occupied by Indian elders could be used to assist existing Indian Title III and Title VI programs, which are presently suffering from limited staff.

We believe that a national Indian Title V contract is more than justifiable and will enhance the utilization of Title V slots in an economical and culturally appropriate manner, not unlike the specific focus on Black and Hispanic elders being provided by their own national advocacy organizations.

Title VI

Increased participation and funding for Title VI are also a very high priority among Indian tribes and organizations. This special Title took a tremendous amount of time and effort to become reality during the 1973 Older Americans Act amendment process. Indian elders nationwide welcomed the intent of the Title, and had great expectations with regard to it's impact. Although it is understood that Title VI was not meant to solve all Indian aging concerns, enough funds to implement the Title effectively were expected.

However, since slightly over one-fourth (1/4) of the Indian tribes, or 134 tribes, have Title VI grants; and these grantees are able to serve only an average of 50% of their elders; therefore, essentially only one-eighth (1/8) of the eligible Indian elders are served under Title VI. We recognize that this is contrary to official AoA figures on record, but it is important that the true situation be made known. The truth being that fewer elders are served and fewer services are provided than were intended when Title VI was introduced nearly nine years ago. Limited Title VI services are becoming restricted even further as new grantees have been added every year with no commensurate increases in funding. On the surface, the addition of new grantees would lead the observer to assume that there has been increased minority participation, while in actuality the grantees already in existence are destabilized as their program funds are reduced to accommodate the incoming grantees.

The rationale and justification for this destabilizing approach have yet to be satisfactorily explained. However, rather than dwelling on the problem, the solution we recommend to accomplish the mandates of Title VI is as follows:

a) increase the current funding level of $7.5 million by an average of $20,000 per grantee to restore current grantees to their 1984 maximum level of funding;

b) increase the current level of $7.5 million by an additional 9% to account for inflation since 1984 (or 3 years x 3%);

c) increase funding for the next five years by $2.4 million per year, to permit the addition of 24 new grantees per year at an average of $100,000 per grantee; in order to arrive at a target of 50% of the federally-recognized tribes having Title VI programs by 1992;

d) factor in an additional 3% per year for the next five years in order to account for projected inflation;

e) these recommendations would result in the following funding schedule:

FY	1988	$ 12.1 million	158 grantees
FY	1989	$ 14.9 million	182 grantees
FY	1990	$ 17.7 million	206 grantees
FY	1991	$ 20.6 million	230 grantees
FY	1992	$ 23.6 million	254 grantees

Other Major Concerns

1) We wish to make clear that we strongly support the concerns of urban Indian elders who have their own unique geographical, social, economic and daily living needs which warrant the attention of Congress. Forty-eight percent (48%) of the Indian elders population live in urban areas. It is essential to develop initiatives toward this often-neglected population.

2) We strongly recommend that an inter-agency memorandum of agreement, including but not limited to the Administration on Aging, the Bureau of Indian Affairs and the Indian Health Service, be required by the Congress to enhance coordination of each agency's mutual and equal responsibility to the Indian elder.

3) On the other hand, we strongly oppose any such measure which would require that the eligibility age for programs under the Act be placed at 70 years of age or older. Our opposition is based on the fact that most minority people have a life expectancy which is less than 70 years, and therefore, would not live long enough to qualify for assistance. Similarly, we oppose any provision which would target the "vulnerable and frail elderly" if such targeting would result in the exclusion of any Indian or other minority elderly from receiving services. This opposition is based on the knowledge that the AoA definition of "vulnerable and frail" is limited to elderly persons who are in immediate jeopardy of institutionalization. Such targeting could have the effect of eliminating many minority and low income individuals who would otherwise qualify for services.

4) We also strongly oppose the consolidation of OAA funds through block grants, or "generic funding." The awarding of such block grants through the states would compromise the sovereign relationship of the tribes with the federal government, and would not be in keeping with the original intent of Congress in designating specific funding for specific purposes when the Act was originally passed.

In, conclusion, we appeal to you, respected members of this

Subcommittee, who must not only monitor, but also reflect the national conscience in your decisions: in this country where millions of immigrants and refugees have, for the first time in their lives, been given the opportunity for social and economic prosperity beyond their most ambitious aspirations, is it too much to ask that changes be made in the law which will provide the opportunity to meet the basic needs of the original inhabitants of our land?

For the crippled elder in South Dakota who has to make her way to her outdoor bathroom at night, for the elder in Navajo who eats only cereal at the end of each month because his food supply is running out, for the elder in New Mexico who is 60 miles from a hospital with no transportation or family support, and for the elder who sits hopelessly in an off-reservation nursing home in the loneliness and isolation of a foreign environment, we hope your answer is that it is not too much to ask.

During this era, where it is fashionable to take up the cause of seals, whales, and exotic birds, we respectfully call upon you, as the primary decision makers of our land, to support the cause of very special human beings who have real feelings, real needs, and a long history of pride and compassion for their fellow man -- the Indian elders.

With these comments, on behalf of the National Indian Council on Aging and of more than 175,000 Indian elders, we call for the reauthorization of the Older Americans Act with our proposed amendments, and we thank you for hearing our concerns, Mr. Chairman, I respectfully request that the complete written text of our testimony with its attachments be included in the official record of these hearings. Thank you.

'87 MAY 18 AM 9 08

NATIONAL INDIAN COUNCIL ON AGING, INC.
P.O. BOX 2088 • ALBUQUERQUE, NEW MEXICO 87103 • (505) 242-9505

May 14, 1987

Honorable Spark Matsunaga
United States Senate
Committee on Labor and Human Resources
SD 428, Attn: Mr. Powell
Washington, DC 20510

Dear Senator Matsunaga:

Ya a teh! ("Hello' in Navajo). Please find enclosed the finalized version of my testimony provided before the Senate Subcommittee on Aging on Thursday, April 23, 1987. Thank you for allowing me to testify on behalf of the National Indian Council on Aging. Also enclosed is:

(1) Exhibit A, entitled -- "Analysis of Title V of the Older American's Act and it's Limited Impact on Native American Elders." This exhibit should be printed directly following my written testimony, and

(2) The Spring issue of Generations, a national aging publication, that features an article I wrote about my grandparents, entitled, "Living and Dying the Navajo Way." I'd like to give this article to you to express my sincere appreciation for the concern and respect you have shown toward our nation's Indian elders at a very critical time.

Your support for Indian Aging concerns is greatly appreciated. Should you need further assistance, do not hesitate to call upon the National Indian Council on Aging in the future.

Sincerely,

Ken White
Program Specialist
National Indian Council on Aging

KW:ejg
Enclosures

ANALYSIS OF TITLE V OF THE OLDER AMERICANS ACT

AND

ITS LIMITED IMPACT ON NATIVE AMERICAN ELDERS

BY

Ken White
Program Specialist

National Indian Council on Aging, Inc.

March 09, 1987

TITLE V SUMMARY

The data is displayed on four charts and is based on four sources:

(a) The June, 1985 Year End Report submitted to the Department of Labor by National Title V Contractors;

(b) The June 30, 1986 Year End Report submitted to the Department of Labor by National Title V Contractors;

(c) The December 31, 1986 Quarterly Progress Report submitted to the Department of Labor by National Title V Contractors;

(d) Information provided directly by National Title V Contractors to NICOA.

1. CHART I COMPARISON OF THE NUMBER AND PERCENTAGE OF NATIONALLY CONTRACTED TITLE V POSITIONS AND SUBCONTRACTORS TO NATIVE AMERICAN TITLE V POSITIONS AND SUBCONTRACTORS

As indicated on Chart I, there were a total of 49,559 Senior Community Service Project positions reported by National Contractors.

Of these, 742 positions are specifically targeted for Indian elders. This represents 1.50% of the total allocation of nationwide positions.

Secondly, through the 8 major contractors there are a total of 437 Senior Community Service Project subcontractors/sponsors/offices nationwide*. Of these, 1 subcontract is specifically targeted to Indian Tribes. This represents .23% of the total subcontractors/sponsors/offices nationwide.

2. CHART II COMPARISONS OF 1985 YEAR END STATISTICS TO 1986 YEAR END STATISTICS RE: NATIONALLY CONTRACTED TITLE V POSITIONS AMONG ETHNIC GROUPS

When comparing data for June, 1985 to June, 1986, figures indicate Native Americans received the lowest number of positions; the lowest number of position increases; and the lowest percentage of increase in 1985 and 1986 among all ethnic groups nationwide.

3. CHART III **COMPARISON OF THE NUMBER AND PERCENTAGE OF TOTAL STATE UNIT ON AGING TITLE V POSITIONS TO TOTAL STATE UNIT ON AGING INDIAN TITLE V POSITIONS IN 7 STATES**

Data focuses on Title V positions provided by State Units on Aging in 7 states with large Native American populations. The figures indicate there were 69 Indian Title V positions out of 2,173 total Title V positions provided by State Units on Aging in the seven (7) identified states. These 69 Indian Title V positions represent 3.18% of the total number of Title V positions allocated to the 7 State Units on Aging.

4. CHART IV **SUMMARY STATISTICS: TITLE V, ALL SOURCES**

Data indicates there were 78,963 total Title V Positions nationwide. This figure includes both National Contractors and State Units on Aging Positions for the time period ending June 30, 1986. Based on totals of both sources, there were 1,256 total Indian Title V Positions reported by National Contractors and State Units on Aging. This represents 1.59% of the total number of Title V Positions allocated nationwide.

CHART I

Date MARCH 09, 1987

COMPARISON OF THE NUMBER AND PERCENTAGE OF NATIONALLY CONTRACTED TITLE V POSITIONS and SUBCONTRACTORS TO NATIVE AMERICAN TITLE V POSITIONS and SUBCONTRACTORS

CONTRACTOR	# OF SCSP POSITIONS	# OF SCSP SUBCONTRACTORS	# OF INDIAN SCSP SUBCONTRACTORS	# OF ALLOCATED INDIAN POSITIONS	% OF TOTAL POSITIONS vs INDIAN POSITIONS	% OF TOTAL SUBCONTRACTORS vs INDIAN SUBCONTRACTORS
1) American Association of Retired Persons	7,670	100 offices in	0	66*	.86 %	0 %
2) National Council on Aging	6,015	63	1	119	1.98 %	1.59 %
3) National Council of Senior Citizens	9,764	146	0	78*	.80 %	0 %
4) Green Thumb	16,469	32 unit offices in 43 states	0	340	2.06 %	0 %
5) Asociacion Nacional Pro Personas Mayores	1,628	a) 9 regional offices; b) 4 subgrantees = 13 TOTAL	0	28	1.72 %	0 %
6) National Caucus on the Black Aged	1,794	10 offices in 10 states	0	3*	.17 %	0 %
7) National Urban League	1,946	23 Affiliated offices	0	8*	.41 %	0 %
8) U.S. Forest Service	4,273	40 states*	0*	100*	2.34 %	0 %
TOTALS:	49,559	437 subcontractors/sponsors/offices	1	742	1.50 %	.23 %

SOURCES:
(A) * 06/30/86 DOL Year End Report.
(B) 12/31/86 DOL Quarterly Progress Report.
(C) Information provided by National Contractors.

CHART II

Date March 06, 1987

COMPARISONS OF 1985 YEAR END STATISTICS TO 1986 YEAR END STATISTICS RE: NATIONALLY CONTRACTED TITLE V POSITIONS AMONG ETHNIC GROUPS

Conducted by NICOA, Inc.

JUNE, 1985: 65,807 TOTAL POSITIONS			JUNE, 1986: 66,511 TOTAL POSITIONS			COMPARISONS	
Ethnic Group	# of Positions	% of Total Positions	Ethnic Group	# of Positions	% of Total Positions	Increases/Decreases in Positions from June, 85 - June, 86	% of Increases/ Decreases from June, 85 - June, 86
White	42,937	65.25 %	White	42,896	64.49 %	- 41	- .76 %
Black	14,980	22.76 %	Black	15,386	23.13 %	+ 406	+ .37 %
Hispanic	5,087	7.73 %	Hispanic	5,364	8.06 %	+ 277	+ .33 %
Pacific Asian	1,787	2.72 %	Pacific Asian	1,837	2.76 %	+ 50	+ .04 %
Native American	1,016	1.54 %	Native American	1,028	1.55 %	+ 12	+ .01 %
	65,807	100.00 %		66,511	100.00 %		

SOURCE: Department of Labor Year End Report for 8 National Title V Contractors.

CHART III

Date March 09, 1987

COMPARISON OF THE NUMBER AND PERCENTAGE OF TOTAL STATE UNIT ON AGING TITLE V POSITIONS TO TOTAL STATE UNIT ON AGING INDIAN TITLE V POSITIONS IN 7 STATES

STATE	ADMINISTERED BY	# OF SCSP POSITIONS	# OF ALLOCATED INDIAN POSITIONS	% OF TOTAL POSITIONS vs INDIAN POSITIONS
1) Arizona	Department of Economic Security	355	6	1.69 %
2) California	State Department on Aging	1,026	9	.87 %
3) New Mexico	State Unit on Aging	64	4	6.25 %
4) Oklahoma	JTPA Office	197	14	7.10 %
5) Washington	State Unit on Aging	180	8	4.40 %
6) Minnesota	JTPA Office	301	26	8.63 %
7) Nebraska	State Unit on Aging	50	2	4.00 %
TOTALS:		2,173	69	3.18 %

SOURCE: DOL 06/30/86 DOL Year End Report

CHART IV

Date MARCH 06, 1987

NATIONAL CONTRACTORS June, 1986: 66,511 Total Positions			STATE UNITS ON AGING June, 1986: 12,452 Total Positions			TOTALS (of National Contractors & State Units on Aging) June, 1986: 78,963 Total Positions		
Ethnic Group	# of Positions	% of Total Positions	Ethnic Group	# of Positions	% of Total Positions	Ethnic Group	# of Positions	% of Total Positions
White	42,896	64.49 %	White	7,762	62.34 %	White	50,658	64.15 %
Black	15,386	23.13 %	Black	2,686	21.57 %	Black	18,072	22.89 %
Hispanic	5,364	8.06 %	Hispanic	815	6.55 %	Hispanic	6,179	7.83 %
Pacific Asian	1,837	2.76 %	Pacific Asian	961	7.72 %	Pacific Asian	2,798	3.54 %
Native American	1,028	1.55 %	Native American	228	1.83 %	Native American	1,256	1.59 %
	66,511	100.00 %		12,452	100.00 %		78,963	100.00 %

SOURCE: 06/30/86 Department of Labor Year End Reports for (A) National Contractors; (B) State Units on Aging.

STATE OF HAWAII
OFFICE OF HAWAIIAN AFFAIRS
1600 KAPIOLANI BLVD., SUITE 1500
HONOLULU, HAWAII 96814
(808) 548-8960

TESTIMONY FROM THE OFFICE OF HAWAIIAN AFFAIRS SUBMITTED TO THE U.S. SENATE SUBCOMMITTEE ON AGING, COMMITTEE ON LABOR AND HUMAN SERVICES IN SUPPORT OF THE OLDER AMERICANS ACT OF 1987, S. 887

Aloha Senator Matsunaga and member of the committees. The Office of Hawaiian Affairs (OHA) appreciates the opportunity to submit this late testimony to the committee in support of the Reauthorization of the Older Americans Act of 1987.

Before continuing however, the following background information on the Office of Hawaiian Affairs is a means of providing the members of the committee with some understanding of the interest and responsibilities of OHA in this, and all matters dealing with the Hawaiian people.

THE OFFICE OF HAWAIIAN AFFAIRS

According to legislation creating the Office of Hawaiian Affairs, it is the "principal public agency in Hawaii responsible for the performance, development, and coordination of programs and activities relating to Native Hawaiians." It is governed by a nine-member Native Hawaiian Board of Trustees elected by approximately 44,000 Native Hawaiians. As a result, the OHA trustees are directly accountable to their beneficiaries, the Native Hawaiian people.

OHA was created in 1978 by an amendment to the Hawaii State Constitution. The basis for its establishment, however, dates back to our State Admissions Act of 1959. The Act created a public land trust, the proceeds of which were to be used for five purposes. One of the purposes was the betterment of conditions for Native Hawaiians.

In 1979, the State Legislature passed Act 196 which established the basic structure of OHA. This Act was subsequently codified as Chapter 10, Hawaii Revised Statutes. It mandates OHA to serve as a receptacle for reparations and to act as a clearinghouse for federal or state assistance involving Hawaiian programs and projects. OHA is also responsible for advising, informing and coordinating federal, state and county activities relating to Native Hawaiian programs. It is with this role in mind that OHA submits this testimony today.

OLDER AMERICANS ACT

In 1986, OHA published the final report of the Population Survey Needs Assessment (PS/NA) identifying physical, sociological, psychological and economic needs of Hawaiians. This is the first comprehensive survey using a statewide stratified random sample, ensuring results that are truly representative of the Hawaiian community. Among other things, persons surveyed put a high priority on the need for services such as those provided in the Older Americans Act.

OHA therefore echoes the testimony of the Director of the Department of Social Services and Housing for the State of Hawaii, Winona Kealamapuana Rubin urging amendments to S. 887 as follows:

+ Hawaiians presently comprise over 19% of the state population, and approximately 9% of those 60± years or older, but are not represented in that proportion on current advisory councils. We suggest a requirement for minority representation on councils to be in proportion to the minority's representation in the total population of the area served by the council.

+ Reaffirm the commitment of Congress to the language of the Act providing service to persons with the greatest economic and social needs in a culturally sensitive manner through an amendment which will provide some flexibility in hiring personnel in Section 307(a)(20)(B). Language should indicate plural rather than singular "...individual(s) employed...".
+ Including Native Americans in the Older Americans Act of 1987 and any future appropriate legislation would be consistent with Congressional intent which has included Native Americans in legislation for vocational education, mental health, employment, community social and economic development, religious freedom and culture and the arts.

The Office of Hawaiians Affairs sincerely appreciates the opportunity to support these amendments and to support reauthorization of the Older Americans Act.

SIOUX NATION COMMISSION ON AGING

Iyonne Garreau, *Chairperson*
(Cheyenne River)
Gordon Kitto, *Vice-Chairperson*
(Santee)
Jeanette Two Shields, *Treasurer*
(Standing Rock)
Vienna Bad Milk, *Secretary*
(Pine Ridge)

P.O. Box 784
Eagle Butte, SD 57625
(605)964-8056

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Sub-Committee on Aging

Senator S. Matsunaga

Presented By Wilson Cook

Sioux Nation Commission on Aging

Box 784

Eagle Butte, South Dakota 57625

April 23, 1987

The eagle has held spiritual significance for the Sioux, representing strength and power as well as that of the Great Spirit.

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
Sub-Committee on Aging
Senator S. Matsunaga

Presented By Wilson Cook
Sioux Nation Commission on Aging
Box 784
Eagle Butte, South Dakota

April 23, 1987

Mr. Chairman and members of the Senate Committee on Aging, I am Wilson Cook, an enrolled member of the Cheyenne River Sioux Tribe. I am 72 years of age.

Today, I represent the Sioux Nation Commission on Aging, which is made up of eleven (11) Sioux tribes in a three state area (North Dakota, South Dakota and Nebraska). The total population of the Sioux tribes, according to the Bureau of Indian Affairs, is 51,391. Indian Health Service quotes 8.7% as elderly, are aged 55 and in the Aberdeen Area. Of the Sioux tribes, there are 4,304 elders on the reservation.

All three states are sparsely populated, and most of the reservations are isolated, lacking access to many resources that the more populated states enjoy. For example, a population distribution of nine (9) persons per square mile in the state of South Dakota is indicative of the isolation of individuals from one another.

Over the last several years, not only has the private sector on the reservation faced problems, but decreased federal funding has reduced employment, direct services and staff to work with Indian people. Geographic distances make communication between state, tribal and federal agencies extremely difficult.

There is a disproportionately high number of Indian elders that are in poverty, and one of the biggest barriers in the delivery of services, is the great distances one must travel to receive and provide services. This, in turn, impacts the flow of information directed toward the elders as well, which again presents another barrier for the delivery and utilization of available resources.

One of the major goals of the Sioux Nation Commission on Aging is to ensure that the voice of the Indian elderly are heard on a tribal, state and federal level. We have been actively assisting the National Indian Policy Task Force under the National Indian Council on Aging, to develop the legislation needed for an Indian Aging policy. In addition, we have also developed some amendments to the Older Americans Act that will reflect some necessary changes that we feel need to occur. The elderly want to live in their own communities with a sense of future and a sense of opportunity within the full scope of their communities. We want to be near our grandchildren to provide wisdom and guidance to them as they grow.

One of the more vital health services is nutrition. I would like to share my personal experience with you. I serve as Chairman of the Elderly Advisory

Board for the Cheyenne River Elderly Nutrition Service program. I watched the program expand nutrition service to our outlying communities. I observed the excitement of our elderly as they organized their local advisory boards. We recognized, at the beginning of the program, the need to raise funds to supplement our federal dollars. Through the nutrition program, other services were made available to our elders which include health and nutrition education. The elderly were given an opportunity to plan their own activities. The program grew from one nutrition center to eight centers. Now, due to funding reduction, we have been reduced to only three centers. We are still fundraising, and we also have a garden project to help supplement our program costs. The Title VI funding level is just not adequate to meet the needs of our elders. On Cheyenne River alone, we are providing nutrition services to 200 older Indians, age 60 and older, when we have a total of 363 older Indians of the same age who are in need of these same services.

We respectfully request that you review the proposed amendments to the Older Americans Act and act favorably on them. The existing law is clear in that "preference will be given to provide services to older individuals with the greatest economic or social needs with particular attention to low income minority individuals".

The general economy of Sioux country today is at an all time low. Our ranchers and farmers, non-Indian and Indian together, are going bankrupt on our reservations, which is representative of all the reservations in Sioux country. Our people suffer from the lack of opportunity and economic justice. There was a time when we, the Lakota Nation, would go to the sacred land and pray for salvation. Today, even the Paha Sapa (Black Hills) is far from us. The Great Spirit moves across Lakota country, but resides as a haven in the shadow of the Black Hills.

Our people cry out for the right to survive. We, the old, remember what they said to us when they gave us the Indian Reorganization Act. It was the promise of economic life. We have pride in who we are. We do not beg for these things. I fought for this great country in World War II under General Eisenhower. I come before you with dignity to ask for what is our right as a proud people.

Our Indian farmers and ranchers are slowly vanishing. Our young fight daily because of the lack of work, and most find disappointment and frustration. They turn to drugs and alcohol. The pain of the aged is the pain of realism. Give us the tools to help us wage our battles, whether it be in the form of nutrition or in-home care.

On behalf of the Sioux Nation Commission on Aging, I submit to you the proposed amendments to the Older Americans Act herein attached, and request your favorable consideration. Thank you for allowing me to testify on behalf of all the Indian elders.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Administration on Aging

Office of Assistant Secretary
Washington DC 20201

SEP - 5 1986

First Annual Conference
Sioux Nation Commission on Aging
"We're Talking But Who's Listening"

Pierre, South Dakota
October 8, 1986

Dear Colleagues:

I wish to extend my greetings to you as you participate in the First Annual Conference of the Sioux Nation Commission on Aging. I hope you find the sessions educational and enjoyable.

In these challenging times, we must continue to build comprehensive, coordinated community-based systems of care for older Americans--a population which in the near future will be far larger in number than the current elderly population. We must develop and strengthen partnerships with all those who work with and for older Americans, both on Indian reservations and in other parts of the country. These include older people, family members, Tribal officials, other elected officials, business leaders, informal caregivers, voluntary organizations, service providers, educational institutions and so many others. We must work together more effectively to assure that your vulnerable elderly Tribal members, those threatened with the loss of their independence, have the opportunity to continue to live dignified, meaningful and independent lives in their own homes as long as possible.

As you participate in this conference, I urge you to reaffirm your commitment to work together--to pool dollars, ideas and manpower. As you return to your homes, I urge you to collaborate on practical solutions that help those truly in need. Together we need to do all we can to make growing old in America a rewarding experience. I pledge my Agency's continued support for State and Area Agencies on Aging and Indian Tribal Groups, in order to make a better life for all older people, including Indian elderly. None of us can be successful alone. Together we can make a difference.

Sincerely,

Carol Fraser Fisk

Carol Fraser Fisk
Commissioner on Aging

SIOUX NATION COMMISSION ON AGING

Resolution No. 1-14-87-1

WHEREAS, The Sioux Nation Commission on Aging is incorporated under the state of South Dakota as a non-profit organization to promote issues and concerns confronting the Indian elderly; and

WHEREAS, The Commission's purpose is to provide a forum for the Indian elderly to communicate their needs, concerns and problems, and to ensure that benefits and services are provided in a manner that preserves and restores their dignity, self-respect and cultural identity; and

WHEREAS, The first annual conference of the Sioux Nation Commission on Aging was hosted in Pierre, South Dakota, and the theme was entitled "We're Talking But Who's Listening"; and

WHEREAS, The Sioux Nation Commission on Aging recognizes that the present system within the Bureau of Indian Affairs Social Services does not include specific services for the elderly; and

WHEREAS, The present "Monthly Narrative Report" of the B.I.A. Law Enforcement does not identify the ages of male/female that would document the abuses/complaints of the Indian elderly.

NOW THEREFORE BE IT RESOLVED, that the Sioux Nation Commission on Aging requests the B.I.A. Area Director, Dr. Jerry Jaeger, to immediately begin a personnel job classification revision and create or designate an Indian Elderly Social Worker position at each local agency.

BE IT FURTHER RESOLVED, that these said positions be contracted by the Sioux Nation Commission on Aging through United Sioux Tribes to implement on each reservation.

BE IT FURTHER RESOLVED, that the Sioux Nation Commission on Aging requests the B.I.A. Area Director, Dr. Jerry Jaeger, to immediately begin a revision to the "Monthly Narrative Report" of the B.I.A. Law Enforcement to include the identification of the ages of male/female.

CERTIFICATION

WE DO HEREBY CERTIFY: That the Sioux Nation Commission on Aging passed this resolution at a duly called meeting of the Board of Directors on the 14th day of January, 19 87 at United Sioux Tribes Development Corporation in Pierre, South Dakota.

[illegible] Garreau

Chairperson

SIOUX NATION COMMISSION ON AGING

HISTORY

Since September of 1984, the Sioux Nation Commission on Aging has made great strides in organizing and coordinating efforts to focus statewide attention on the Indian elderly. Recognizing the need for stop gap services when Title VI monies had been cut, the current officers began making contacts around the country to determine what could be done to restore funding or utilize other available resources.

In April of 1985, the officers requested United Sioux Tribes' help in their efforts to gather federal, state and tribal resources together to set a plan of action in motion and look at ways these entities could not only share information, but better coordinate their resources. United Sioux Tribes contacted the regional office of the Administration on Aging in Denver, the state of South Dakota - Adult and Aging Services, Bureau of Indian Affairs (Aberdeen) and Indian Health Service (Aberdeen) to join the Commission and share information on the type of services available for the Indian elderly through their respective agencies.

Two goals were set for 1985 and have been accomplished: (1) To formalize an aging network within the state of South Dakota for the benefit of Indian elderly and those programs and agencies involved; and (2) To develop an information directory on resources available for elderly programs to be used by those organizations involved. There is a lack of Title VI involvement which has yet to be resolved.

Three more goals were achieved than were originally set. First, it provided an environment and opportunity for the state and federal agencies to coordinate their efforts and more efficiently utilize existing resources. Second, the effort focuses attention on a very valuable and somewhat neglected resource for Indian country, the Indian elderly. Third, this effort offers the opportunity and support for the elderly to speak up on issues that they feel are important.

INCORPORATION

On April 4, 1986, the Sioux Nation Commission on Aging became incorporated under South Dakota state laws as a non-profit organization.

On October 7, 1986, all eleven (11) board members were sworn in and seated on the Commission. October 8, 1987, was the first annual conference for the Commission. 145 people from four states attended. The bulk of the participants were the Indian elders themselves. The Commission is now finalizing 1987 goals and plans for the Commission to address.

The eagle has held spiritual significance for the Sioux, representing strength and power as well as that of the Great Spirit.

PROPOSED AMENDMENTS
TO
THE OLDER AMERICANS ACT, 1987

TITLE I

Section 102 (5) Add "as defined by that tribe." The definition would then read as follows: The term "Indian" means a person who is a member of an Indian tribe as defined by that tribe.

TITLE II

Section 204 (a)(1) Federal Council on Aging

Insert "Indian tribes" following the words "business, labor, minorities, ..." It would then read: Members shall be appointed by each appointing authority so as to be representative of rural and urban older individuals, national organizations with an interest in aging, business, labor, minorities, Indian tribes, and the general public.

Section 212. Contracting and Grant Authority

Create a subsection (a) to read as Section 212 now stands, and add a new subsection (b) to read: (b) None of the provisions of this Act shall be construed to prevent an Indian tribe or Indian organization which is a recipient of a grant or contract from entering into an agreement, subject to the approval of the Associate Commissioner on Indian Aging, with a profitmaking organization to carry out the provisions of this Act.

Section 213. Surplus Property Eligibility

Identify the present Section 213 as subsection 213 (a), and add a new subsection (b) to read:

(b) Any Indian tribe, or Indian tribal organization, or nonprofit Indian organization or institution, which receives funds appropriated for programs for older individuals under this Act, under titles III, IV, V or VI or title XX of the Social Security Act, or under titles VIII and X of the Economic Opportunity Act of 1964, and the Community Services Block Grant, or under (list the various related Indian statutes/titles) shall be deemed eligible to receive for such programs property which is declared surplus to the needs of the Federal Government in accordance with laws applicable to surplus property.

TITLE III

Purpose; Administration

Section 301 (a) insert "and with Indian tribes and Indian tribal organizations" after the words "new cooperative arrangements in each State with State and area agencies;" The section would then read: It is the purpose of this title to encourage and assist State and area agencies to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated service systems to serve older individuals by entering into new cooperative arrangements in each State with State and area agencies; and with Indian tribes and Indian tribal organizations; and with providers including voluntary organizations, of supportive services, including nutrition services and multipurpose senior centers, for the planning, and for the provision of, supportive services, nutrition services, and multi-purpose senior centers in order to -- ...

"Insert new heading after Section 302":

COORDINATION OF SERVICES BETWEEN TITLE III AND TITLE VI

(a) No Indian elderly person shall be prohibited from receiving Title III services based solely on the fact that Title VI services are provided to his/her tribe.

(b) Each area agency on aging, in order to be approved by the state agency, shall assure the use of outreach efforts that will identify Indian individuals eligible for assistance under this Act, and inform such Indian individuals of the availability of such assistance.

(c) For purposes of this Title the age of eligibility is 60 years of age or older.

(d) The Associate Commissioner on Indian Aging shall monitor, evaluate, and recommend to the Commissioner, whether adequate Title III services are being administered to Indian individuals as identified pursuant to new subsection (b) (above).

Organization

Section 305 (c)(4) insert a new subsection number (5) after Section 305 (c)(4) to read: (5) an Indian tribe, organization, or consortium; or

Section 305.(d)(2) insert "or geographic" after the words "physical and mental disabilities, language barriers and cultural or social ..." The wording would then be: ... 'greatest social need' means the need caused by noneconomic factors which include physical and mental disabilities, language barriers and cultural or social or geographic isolation including that caused by racial or ethnic status ...

NOTE: Need to request report language re-emphasing Section 306.(a)(5)(A) to assure more effective targeting and compliance with this section of the Older Americans Act.

TITLE IV

Section 410. add a new subsection (6) to read:

establishing and supporting minority centers of gerontology and providing special emphasis that will improve, enhance, and expand existing minority training programs.

Section 411.(a) add a new subsection (4) to read:

To provide dissemination of information on Indian aging to the public, and to provide in-service training and courses on aging to Indian tribes through a public non-profit Indian aging organization.

Section 412. (a) The Commissioner may make grants to public and private nonprofit agencies, organizations, and institutions for the purpose of establishing or supporting multidisciplinary centers of gerontology, and gerontology centers of special emphasis (including emphasis on nutrition, employment, health, income maintenance and supportive services ... and minority populations ... Such centers shall conduct research and policy analysis ... etc., etc.

NOTE: Need to request report language re-emphasizing Section 422(b)(6), and requiring a comprehensive study on Indian aging.

Section 423 (a)(1) add at the end of subsection (B):

Grants so provided under this title shall be awarded equitably among minority organizations so as to meet the targeting provisions of the Act.

TITLE V

NOTE: Need report language re-emphasizing Section 502(b)(1) with assurances that Title V contracts will also be made with tribal organizations or Indian organizations in accordance with the language of this section.

Section 502 (b)(1)(M) Will assure that, to the extent feasible, such project will serve the needs of minority, Indian and limited English-speaking, and Indian eligible individuals in proportion to ~~their numbers in the State~~ the rates of poverty and unemployment experienced by these populations; and

PROPOSED AMENDMENTS
TO
THE OLDER AMERICANS ACT, 1987

TITLE VI

Statement of Purpose

Section 601.

(a) It is the purpose of this title to incorporate fully the objectives of Section 101 in the execution of this title.

(b) It is also the purpose of this title to promote the delivery of supportive services, including nutritional services for Indians that are comparable to services provided under Title III.

Findings

Section 602. The Congress of the United States finds that the Indian elderly of this country are:

1. Increasing in population from 64,000 in 1970 to 109,000 in 1980; and it is projected that this population will increase to over 200,000 by 1990; and
2. Unemployed at a rate exceeding 80%; and
3. Living in poverty at a rate of 61%; and
4. Have a life expectancy between 6 and 8 years less than the general population; and
5. Impacted by the lack of nursing homes (there are currently nine (9) nursing homes on Indian reservations, with a total of 532 beds); and
6. Impacted by the lack of Indian Area Agencies on Aging (there are currently 9 out of a total of 673 Area Agencies on Aging in the nation); and
7. Living in substandard and over-crowded housing; and
8. Receive less than adequate health care; and
9. Are served under Title VI of the Older Americans Act at a rate of less than 25% of the total reservation Indian elderly population; and
10. Are served under Title III of the Older Americans Act at a rate of less than 1% of the total participants; and

11. Are being physically and mentally abused, affecting an estimated 30% of the nation's Indian elderly population; and

12. Are being excluded from benefits under Social Security at a rate of approximately 57% of the nation's Indian elderly population.

Declaration of Policy

Section 603. The United States Government and the Congress have a legal and moral obligation to Indian Tribes as established by treaties, statutes, Executive Orders, and the Constitution of the United States. The Congress of the United States recognizes Indian and Alaskan Native elderly as a vital resource and entitled to all benefits and services available; and that these services and benefits shall be provided in a manner that preserves and restores the dignity, self-respect and cultural identity of Indian elderly persons.

Eligibility

Section 604.

(a) A tribal organization of an Indian tribe is eligible for assistance under this title only if --

  1. the tribal organization represents at least 50 individuals who have attained 60 years of age or older; or at the discretion of the Associate Commissioner for Indian Aging, who may approve, upon request by a tribe, an eligibility age of 55 years or older;

  2. the tribal organization demonstrates the ability to deliver supportive services, including nutritional services.

Delete subsection 3 of old Section 602 (a).

INDIAN DESK

TITLE VI-GRANTS FOR INDIAN TRIBES

Section 605.

(a) In establishing regulations for the purpose of this title the Commissioner shall consult with the Secretary of the Interior.

(b) There is established in the office of the Commissioner an Associate Commissioner for Indian Aging.

(c) It shall be the duty and function of the Associate Commissioner for Indian Aging to:

1. Serve as the effective and visible advocate within the Department of Health and Human Services and other departments and agenices of the federal government over all federal policies affecting the Indian elderly;
2. Coordinate between other federal departments and agencies to assure a continuum of improved services; through memoranda of agreement;
3. Administer and evaluate the grants provided by this Act for Indian tribes; in particular coordination of Title III services, pursuant to (new section on Coordination of Services under Title III);
4. Develop basic policies and set priorities with respect to the development and operation of programs and activities conducted under the Act;
5. Collect and disseminate information related to problems of the Indian elderly;
6. Develop plans, conduct and arrange for research in the field of Indian aging; with a special emphasis for ongoing gathering of statistics on the status of Indian elderly;
7. Develop and provide technical assistance and training programs to Title VI grantees;
8. Convene an Indian aging conference at regular intervals;
9. Chair an interagency task force on Indian elderly and report to the Commissioner the task force findings and recommendations.

Grants for Indian Tribes/Title VI -- Page Two

(d) Indian preference in hiring shall be observed pursuant to P.L. 93-638.

(e) There shall be appropriated such sums as may be necessary to carry out the functions of this office.

(f) Programs and statutes related to this Act include, the Indian Health Care Improvement Act, the Indian Self-Determination Act, the Drug and Alcohol Act _____, and others as relevant.

TITLE VI STUDY

The Associate Commissioner on Indian Aging shall complete a study within 18 months to determine the following:

1. Determine how many Indian elderly now participate in Title III and Title VI programs as compared to how many elderly are eligible.
2. Determine how Title III and Title VI grants and services are made to Indian persons and tribes.
3. Analyze and recommend whether an interagency task force would facilitate coordinated and improved services to Indian elderly.
4. Determine what services are currently provided through Title VI to Indian elderly. And how will the Administration on Aging assure that supportive services to Indians are commensurate with Title III services such as: information and referral, legal services, transportation, and ombudsman.

Rev. 03/16/87

FUNDING FORMULA JUSTIFICATION

This funding formula is based on several documented findings. Although there has been an effort through the Administration on Aging to develop Indian aging programs, the reality for Indian elders is that there remain many unmet needs. Recent surveys by the National Indian Council on Aging have documented this fact, revealing that 7/8 of the reservation elderly population, and the overwhelming majority of the urban Indian elderly do not receive services from any Older Americans Act program (source: NICOA testimony before Senator Don Nickles, June 1986).

In view of the documented need, this funding formula proposed for Title VI of the Older Americans Act is not excessive, but is based on realistic allocations that will allow Indian tribes and organizations to meet basic minimum needs for nutrition and supportive services.

The funding formula is based on several factors; they are:

1. The original appropriation level for Title VI was not sufficient to meet the basic needs of Indian elders in 1980 when Title VI was first funded.

2. The population of Indian elders is projected by the U.S. Bureau of Census to increase to over 200,000 by the year 1990 (almost twice the population of Indian elders in 1980); thus resulting in significantly greater needs.

3. Current Title VI funding levels allow only for provision of nutrition and some transportation by the grantees. Very few grantees are able to provide the supportive services mandated under the Act, simply because of limited funds.

4. Although Title III services are available in some areas, the services are not being effectively targeted toward Indian elders; and the law (as it now reads) prohibits any Title VI participant from receiving Title III services. Participation levels of Indian elders in Title III services are less than 1% of the total participants.

5. There are 504 federally-recognized tribes, but only 124 (less than 1/4) of these receive Title VI funds. These Title VI grantees are able to serve an average of only 51% of their elders due to inadequate funding; 49%, therefore, are left unserved.

Justification -- Page Two

FUNDING FORMULA

1. There are 504 federally-recognized tribes.

2. 124 tribes currently have Title VI grants; 380 do not.

3. Approximately 80%, or 403 of the federally-recognized tribes have elderly populations of 60 or more persons -- the number required for eligibility for Title VI funds under the current Older Americans Act requirements.

4. Since the existing 124 grantees are able to serve only 51% of their elderly populations, an immediate increase in funding of $5.2 million is needed to meet the needs of the remaining elders whom current grantees are now unable to serve. Realistically, a base of $12.4 million is required to meet the needs of elders to be served by existing grantees.

5. From 1988 to 1992, an increase of 56 new Title VI grantees per year will be needed just to meet the target figure of 403 eligible tribes (or 80% of the total). At an average of $100,000 per new grantee (the amount needed to conduct even a minimal program providing nutrition and transportation), an increase of $5,600,000 per year is recommended for each of the next five years.

The funding projections, then, would be as follows:

1988	-	$ 18.0 million*	180 grantees
1989	-	$ 23.6 million	235 grantees
1990	-	$ 29.2 million	291 grantees
1991	-	$ 34.8 million	347 grantees
1992	-	$ 40.4 million	403 grantees

* $12.4 million to current Title VI grantees plus $5.6 million for 56 additional grantees - beginning in 1988.

SIOUX NATION COMMISSION ON AGING

GOALS AND OBJECTIVES

FOR

FISCAL YEAR 1987-88

MISSION

STATEMENT

The Sioux Nation Commission on Aging was formed for the purpose of creating a unified voice for the Indian elderly to communicate their needs, concerns and problems, and to ensure that benefits and services shall be provided in a manner that preserves and restores their dignity, self-respect and cultural identity. It shall be the purpose of the corporation to promote issues and concerns confronting the American Indian elderly through training, sensitizing and advocacy efforts.

GOALS

I. PROMOTE ISSUES AND CONCERNS THROUGH TRAINING.

II. PROMOTE ISSUES AND CONCERNS THROUGH SENSITIZING.

III. PROMOTE ISSUES AND CONCERNS THROUGH ADVOCACY.

The following objectives listed under each goal have been identified by the Indian elderly themselves in July of 1985 and on January 14, 1987.

GOAL #I - PROMOTE ISSUES AND CONCERNS THROUGH TRAINING

Objective - Because of the cutback in Title VI funding which directly affects the Indian elderly on the reservation, there is a need to find additional funds to educate service providers and communities.

Plans

1. Search for additional funding through foundations.
2. Through national Indian organizations, request an increase of Title VI funds.

GOAL #II - PROMOTE ISSUES AND CONCERNS THROUGH SENSITIZING

Objective - There is a lack of responsiveness to the needs of the Indian elderly both on and off the reservation. There is a need to alert those primary service providers, governmental entities, and the local communities of these needs.

Plans

1. Meet with Governors of South Dakota, North Dakota and Nebraska to inform them about Indian elderly concerns and Commission activities.
2. S.N.C.O.A. board members will educate local service unit directors and superintendents on their reservations.
3. Will provide input on problem to the Social Security Administration on SSI monies suspended every year in December.
4. Promote communication between elders and others on and off the reservation.
5. Promote information about available resources for the elders.
6. Advise phone companies and others about the need for lower phone rates.
7. Promote more spiritual communication for the elders.
8. Promote elders teaching more of the young.
9. Make communities aware that there is a lack of recreation/social gatherings that involve the elderly.
10. Sensitize the communities to the need of volunteers for elderly projects.
11. Sensitize the communities to the need of family support and assistance.

12. Sensitize the communities of the lack of positive self-image and recognition by community leaders of the elderly and their concerns.

13. Sensitize the communities to the traditional attitudes of respect accorded to the elders and encourage revival.

GOAL #III - PROMOTE ISSUES AND CONCERNS THROUGH ADVOCACY

Objective - In promoting the issues, governmental entities and communities need to be aware of specific problem areas and the recommendations the elders have made on meeting these needs.

Plans

1. Provide input through the Commission to Congress and other Indian organizations about the need for Title VI increase.
2. Make tribal governments aware of the problem of lack of adequate housing on the reservations.
3. Make tribal government and HUD aware of the need for a ceiling on the HUD rent for the elderly.
4. Make tribal government and state agencies aware of need for emergency energy assistance in the winter.
5. Make recommendations to I.H.S. on the following:
   a. Need for exercise programs for elderly.
   b. More specific information on how's and why's of medication.
   c. Focus on diabetes, hypertension and arthritis.
   d. Need to make sure those elderly with acute/chronic conditions are monitored regularly.
6. Make tribal government and other government entities aware of the lack of transportation in isolated communities.
7. Advocate donation of maintenance of existing vehicles that elderly use.
8. Make H.H.S. aware of the need for home/foster care for elderly who wish to remain in their own home.
9. Make I.H.S., B.I.A. and HUD aware of the wish for nursing homes on the reservations.
10. Request information on the lack of funds for elderly to be placed in nursing homes and what alternatives are available.
11. Make tribal and state governments aware that there is a need for legal services by the elderly.
12. Assist in informing the communities about the need for elderly access to emergency phones.
13. Advocate the development of tribal elderly abuse codes.
14. Provide advocate role for elders on the reservation on legislation that impacts them, keeping them aware of pending changes on the tribal, state and federal levels.

NATIONAL CONGRESS OF AMERICAN INDIANS
Est 1944

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STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS, BEFORE THE SENATE LABOR AND HUMAN RESOURCES SUBCOMMITTEE ON AGING, REGARDING REAUTHORIZATION OF THE OLDER AMERICANS ACT, APRIL 23, 1987, WASHINGTON, D.C.

The National Congress of American Indians (NCAI) appreciates the opportunity to express our views on the reauthorization of the Older Americans Act. We particularly appreciate this Committee's recognition of the special problems of minorities, as evidenced by this hearing devoted to concerns of minority peoples.

The National Congress of American Indians was founded in 1944, and is the oldest and largest national membership organization representing the interests of American Indian and Alaska Native governments and individuals. More than 150 Indian and Native governments are active members of NCAI, and more than 75% of all Indian and Native governments have standing NCAI membership resolutions, representing more than 850,000 Indian and Native people nationwide.

Indian elders hold a central place in Indian cultures. In our societies which have strong oral history traditions, Indian elders are the source of historical continuity and of cultural and religious conservation. Indian elders have been through the 20th Century turmoil of forced relocation from their lands; of the disastrous Allotment Act, which divided Indian lands and made them vulnerable to loss through various unscruplous means; of having their religious practices outlawed; of being forcibly taken away as young children from their families and sent to government boarding schools, where the policy was to strip them of their Indian heritage, including being forbidden to speak their native languages; and of being relocated to cities as part of a 1950s federal policy of assimilation. Even those of us who are middle-aged and younger have been subjected to these oppressive policies. Contrary to turn-of-the century anthropologists' predictions that American Indians were a "vanishing race," we have survived and flourished. We are now the fasting growing population in the United States, despite the fact that we have the lowest life expectancy of any people in the nation. We are trying, despite the obstacles erected by various federal agencies, to take greater control over programs which directly affect our lives. We are increasingly creating our own business, environmental and other codes in order to regulate our own affairs in ways that are consistent with our cultures. We are exercising more control over our schools in order that our children can receive quality educations which are relevant to them and which build self-esteem. Teaching of native languages is common in Indian-controlled schools, and is increasing in public schools with large Indian populations. These positive developments are taking place in spite of the overwhelming poverty among Indian people, but they would not be occurring without the resiliency, determination and the moral leadership of our elders.

The very least that our Indian elders are owed are the basic necessities of good nutrition, health care and adequate shelter. In many instances, these basics are not available to older Indian people. Government policies which took away the resources of Indian peoples and the development of a cash economy have combined to place a majority of Indian elders, and all Indian people, in poverty.

Amendment of the Older Americans Act in 1978 to include a title specific to Indian tribes was very encouraging. Our experience in all federal programs is that there must be an Indian set-aside and an Indian delivery system in order for the programs to be successful on Indian reservations. Title VI of the Older Americans Act has been helpful, but it has been so inadequately funded that only about one quarter of the tribes have grants under this Title. Among the 134 tribes which have Title VI grants, only 50% of their eligible populations are served. We would also point out that in 1985 the number of Indian grantees under Title VI went from 83 to 124 and then to 134 in September of 1986. However, funding for this program has not increased commensurately, as the total appropriation has gone from $5 million, when there were 83 grantees, to only $7.5 million for today's 134 grantees. As a result, programs have had to limit the number of meals they can offer and have had to reduce other services. Title III of the Act, which provides money for states, has served some urban Indian people, but by and large has not been available to tribes.

NCAI is pleased to support amendments to the Older Americans Act, as contained in S. 1069, the Older Americans Indian Services Act, introduced by Senator Bingaman. Our hope is that this bill can be incorporated into the Older Americans Act reauthorization legislation during the mark-up process. The Older Americans Indian Services Act is the result of several years of Indian meetings and discussions, culminating in the proposed National Indian Aging Policy which is the basis for S. 1069.

We support the following amendments to the Older Americans Act:

1) Establishment of an Associate Commissioner on Indian Aging within the Administration on Aging. The Associate Commissioner should be an Indian person. Tribes believe that they have been poorly served by the Office of State and Tribal Programs within the Administration on Aging. During the last reauthorization of the Older American Act, Senator Bingaman wanted to offer an amendment creating an Indian Desk, but withdrew it at the request of the Administration which promised that it would create such a position. This has not happened, and we understand that the Administration on Aging is now opposing the creation of and Indian Desk or Associate Commissioner on Indian Aging.

2) Requirement that the Associate Commissioner on Indian Aging establish an interagency task force on older American Indians for the purpose of studying the availability and quality of services for older American Indians.

3) Requirement that there be an Indian representative on the Federal Council on Aging.

4) Requirement that eligible Indians not be prohibited from receiving services under Title III. We are pleased that the House Education and Labor Human Resources Subcommittee included this provision in its markup of the Older Americans Act reauthorization bill.

5) Requirement of better coordination between the Title III and VI programs, and that Title III programs undertake outreach to Indian elders.

6) Requirement that a contract be awarded to a national Indian aging organization under Title V, the Community Service Employment Program. This is necessary to rectify the current situation where only 1.6% of the total positions under the Senior Community Employment Program are held by Indians. Jobs available under Title V should reflect unemployment and poverty levels, not simply population numbers.

7) Requirement that the research and training provisions of the Older Americans Act be equitably awarded among agencies, organizations and institutions representing minorities.

8) Increase in the authorization of the funding level of Title VI of the Older Americans Act. S. 1069 would authorize the following funding levels: FY1988, $12.1 million; FY1989, $14.9 million; FY1990, $17.7 million; FY1991, $20.6 million; and FY1992, $23.6 million. Under this scenario, 254 grantees could be served by FY1992. These authorization levels are not as high as we or other Indian organizations would like. The original draft of S. 1069 contained higher levels, but for political reasons were decreased. While we support S. 1069, we would like the bill's authorization levels restored to the original $18 million in FY1988, increasing to $40.4 million by FY1992. Under these levels, 403 grantees could be served by FY1992.

Finally, we point out that, in our testimony before the House and Senate Appropriations Committees, we strongly opposed the Administration's FY1988 budget proposal to combine funding for 17 programs within the Department of Health and Human Services, including Administration on Aging programs. Under the proposal, the 17 programs would receive "generic" funding. We do not know how the monies would be allocated among the programs; nor do we know how multi-year contracts would be treated. Further, the awarding of block grants to states is a violation of tribal government rights and would surely weaken the intent of Congress to specify funds for Indian tribes. Thank you for your attention to concerns of Native peoples regarding the Older Americans Act.

Senator **Matsunaga**. Thank you again for appearing. There is now a vote on the floor. I will have to go and vote on the floor. So thank you each and every one of you. Thank you very much.

[Whereupon, at 4:45 p.m., the subcommittee was adjourned.]

OLDER AMERICANS ACT OF 1987

THURSDAY, APRIL 30, 1987

U.S. SENATE,
SUBCOMMITTEE ON AGING,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC

The subcommittee met, pursuant to notice, at 2:35 p.m., in room SD-430, Dirksen Senate Office Building, Senator Spark M. Matsunaga (chairman of the subcommittee) presiding.

Present: Senator Matsunaga.

Also present: Senators Lautenberg and Graham.

OPENING STATEMENT OF SENATOR MATSUNAGA

Senator MATSUNAGA. The subcommittee will come to order.

This is the last of three hearings on the reauthorization of the Older Americans Act being held by the Subcommittee on Aging of the Committee on Labor and Human Resources. The first hearing, held on March 31, addressed the changing needs of the elderly. The second hearing, held on April 23, addressed the needs of minority elders for services under the Act.

In today's hearing we will examine the functioning of current programs to determine whether or not any changes should be provided in the reauthorization legislation to improve and enhance these programs.

We will hear from a diverse group of witnesses, including representatives of the Federal Council on Aging, the Department of Labor, and national aging organizations representing a broad array of services provided under the Act. It is our expectation that these witnesses will, from their direct involvement and experience, address key areas which they believe need to be examined by the subcommittee.

It should be noted that the annual appropriation of $1.2 billion for the Older Americans Act supports not only nutritional programs, which are perhaps the most visible service since they receive 47 percent of the total funding, but also a rich array of other programs and services. These include employment opportunities for low-income elderly, long-term care ombudsman services, senior centers, legal services, elder abuse prevention services, and a wide variety of services which assist older persons to maintain independent living in their community.

We would like to know which of these programs and services should be expanded and which, if any, should be terminated. The broad discretion given to State and area agencies in the provision of services is, in my view, an essential hallmark of the Act. Is it important to maintain this discretion so that the agencies responsible for implementing the Act can be responsive to needs which are identified at the State and local level? We would like to know.

We wish also to examine areas where services authorized or required by the Act need to be strengthened or where program emphasis should be changed. For example, it has been suggested that the long-term care ombudsman program should be amended to be more responsive to the needs of nursing home residents.

With respect to Title V employment programs, suggestions have been made regarding modifications to the administrative cost provisions of the Act. In recognition of the important role that the Title IV discretionary program plays in supporting an aging research agenda focusing attention on new and improved ways of providing services to the elderly and supporting both academic and in-service training programs, we plan to examine how Title IV funds are being used to support our nation's broad goals for the elderly.

At this point I will insert into the record the prepared statement of Senator Hatch.

[The prepared statement of Senator Hatch follows:]

STATEMENT OF SENATOR ORRIN HATCH, UTAH
BEFORE THE U.S. SENATE
HEARING ON REAUTHORIZATION OF THE OLDER AMERICANS ACT
SUBCOMMITTEE ON AGING

SINCE THIS IS THE LAST IN A SERIES OF HEARINGS TO EXAMINE THE OLDER AMERICANS ACT, I ESPECIALLY WANT TO COMMEND SENATOR MATSUNAGA AND THE REST OF THE SUBCOMMITTEE ON AGING FOR TAKING THE TIME TO LOOK AT THIS IMPORTANT LEGISLATION. AS WE KNOW, THE OLDER AMERICANS ACT FUNDS PROGRAMS VERY DEAR TO OUR SENIORS--- SUPPORTIVE SERVICES, NUTRITION PROGRAMS BOTH CONGREGATE AND HOME DELIVERED MEALS, SENIOR CENTERS, TRANSPORTATION AND EMPLOYMENT PROGRAMS. OUR SENIORS WOULD DEFINITELY FEEL A VOID IN THEIR LIVES WITHOUT THESE ESSENTIAL SERVICES PROVIDED BY THE ACT.

ALTHOUGH THE OLDER AMERICANS ACT HAS PROVIDED NECESSARY SOCIAL SERVICES, THE DEMAND ON TITLE III-B FUNDS HAS INCREASED DRAMATICALLY AS A RESULT OF POPULATION GROWTH, MEDICARE CHANGES AND THE INTRODUCTION OF DIAGNOSTICALLY RELATED GROUPS. A NATIONAL STUDY CONDUCTED BY THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER SHOWED A DRAMATIC NEED FOR HOME BASED CARE. THEIR SHOCKING CONCLUSION SHOWED A 196 PERCENT INCREASE IN DEMAND FOR SERVICES WITH EXPENDITURES FOR HOUSEKEEPING AND PERSONAL CARE

AT A 69 PERCENT AND 63 PERCENT INCREASE. THESE DEMANDS CONTINUE TO ESCALATE AND BECOME MORE CRITICAL AS PROGRAMS CUTBACK SERVICE DELIVERY BECAUSE OF DEFICIT REDUCTIONS.

AS MENTIONED IN ANOTHER HEARING, THE OLDER AMERICANS ACT AND ITS SERVICES HAVE AUTOMATICALLY BECOME TARGETED TO THE "OLD-OLD" AND THE FRAIL POPULATIONS. IN THE 1970'S, FUNDS PRIMARILY SUPPORTED THE DEVELOPMENT OF COMMUNITY SERVICES SUCH AS SENIOR CENTERS, TRANSPORTATION AND CONGREGATE MEALS. NOW THAT SAME POPULATION HAS AGED, THEIR NEEDS ARE QUITE DIFFERENT. THEY NOW REQUIRE SERVICES TO HELP THEM REMAIN INDEPENDENT AND IN THEIR OWN HOMES.

IN-HOME SERVICES SUCH AS HOME DELIVERED MEALS, DAY HELP, HOME HELP AND RESPITE ARE MORE COSTLY, BUT THEY ARE CRITICAL FOR INDEPENDENCE. THESE CHANGES IN HOME SERVICES HAVE OCCURRED WITHOUT FORMALLY INCREASING THE AGE OF ELIGIBILITY. INSTEAD, THE EXPLODING GROWTH IN THE NUMBER OF PEOPLE OVER THE AGE OF 80 HAS BEEN THE CATALYST FOR THE SHIFT AND THE STATES HAVE RESPONDED TO THE NEED FOR MORE HOME CARE.

IN RESPONSE TO THE GROWING NEED FOR HOMECARE, I AM GOING TO INTRODUCE SEVERAL HOME HEALTH CARE BILLS. ONE OF MY BILLS WILL DOUBLE THE PERSONAL EXEMPTION FOR FAMILIES THAT TAKE CARE OF AN

AGED FAMILY MEMBER WHO NEEDS MEDICAL SUPPORT. A SECOND BILL AUTHORIZES A DEMONSTRATION PROJECT TO LOOK FOR NEW WAYS TO PAY FOR HOME HEALTH CARE THROUGH THE SAVINGS THAT IT GENERATED. A THIRD BILL REAUTHORIZES THE HOMEMAKER/HOME AID TRAINING GRANT PROGRAM, WHICH PROVIDED FUNDING FOR LOCAL EDUCATIONAL TRAINING PROGRAMS. AND YET ANOTHER BILL PROVIDES $100 MILLION FOR STATE TO PROVIDE HEALTH CARE SERVICES IN THE HOMES OF THE CHRONICALLY ILL. THIS WILL REIMBURSE A PROFESSIONAL HEALTH CARE TEAM TO ASSIST IN THE HOME. I TRULY BELIEVE THAT THIS APPROACH WILL DEMONSTRATE HOW EFFECTIVE HEALTH CARE SERVICES CAN BE WHEN PROVIDED IN THE HOME.

THE NUMBER OF PEOPLE OVER THE AGE OF 80 IN SALT LAKE CITY, UTAH HAS MORE THAN DOUBLED IN THE LAST TEN YEARS. AS HUMAN SERVICE FUNDS HAVE BECOME MORE RESTRICTIVE, AGENCIES NOW HAVE TO ACKNOWLEDGE THAT THEY CANNOT POSSIBLY PROVIDE SERVICES FOR ALL OF THEN ELDERLY. IN UTAH, THEY HAVE PRIORITIZED DELIVERY OF SERVICES TO THE MOST VULNERABLE. IN FACT THE AVERAGE AGE OF CLIENTS IN THE SALT LAKE CITY AREA AGENCY ON AGING IS 74 FOUR YEARS. THOSE IN THEIR SIXTIES ARE ONLY SERVED IF THEY HAVE CHRONIC AND SERIOUS HEALTH PROBLEMS OR ARE SEVERELY ISOLATED. THIS WAS ALL ACCOMPLISHED WITHOUT A MANDATE TO SERVE THE OLDEST FIRST. I WOULD HOPE THAT THE STATE COULD CONTINUE TO HAVE THE

FLEXIBILITY TO PROVIDE SERVICES ACCORDING TO THE NEED AND NOT NECESSARILY THE AGE OF ITS RESIDENTS.

I AM PLEASED THAT I CAN BE AN ACTIVE PARTICIPANT THE THE REAUTHORIZATION OF THE OLDER AMERICANS ACT. I URGE MY COLLEAGUES TO HELP EXPEDITE ITS PASSAGE THROUGH CONGRESS.

Senator MATSUNAGA. Now, before I call upon the panel of witnesses, we have with us two Senators who are very much concerned and involved in programs for the aging. So I would like now for us to call upon Senator Lautenberg of New Jersey.

STATEMENTS OF HON. FRANK LAUTENBERG, A U.S. SENATOR FROM THE STATE OF NEW JERSEY; AND HON. BOB GRAHAM, A U.S. SENATOR FROM THE STATE OF FLORIDA

Senator LAUTENBERG. Thank you very much, Mr. Chairman. I appreciate the opportunity to be with you and commend you for holding this hearing and, of course, your interest in the older American.

The Older Americans Act has been a valuable resource for senior citizens all over the country. For over 20 years, older Americans have received community and social services through the OAA funding, and I am pleased to be a cosponsor of Chairman Matsunaga's bill to reauthorize OAA for another four years.

I would like to share with you my recommendations for two new services to be added to Title III, the part of the Older Americans Act that provides grants for State and community programs on aging.

My first proposal is for in-home services for frail older individuals. In fiscal year 1988, $25 million would be authorized for grants to State to provide in-home services, such as homemaker aides, visiting and telephone reassurance, chore maintenance, or in-home respite care for families.

My second proposal is to authorize periodic preventive health services to be offered at senior centers or other convenient locations. These preventative services would be those not covered by Medicare, such as routine physical exams, immunization, vision and hearing screening, and counseling and referral for follow-up health services.

These relatively modest proposals would make a start in dealing with some important unmet needs of our older constituents. We all know now that people are living longer. Men reaching 85 can expect to live 15 percent longer than men who reached 85 in 1960. For women, the increase is twice as much, 33 percent longer.

The question is whether living longer means living better. Are people staying healthy and vigorous as they live longer? A Canadian study covering 1951 to 1978 found that life expectancy increased by an average of six years, but for almost five of those years a person's activity was limited.

But that does not mean an older person needs to be in a nursing home or another institution. Often, people can stay in their own homes if they receive just a little assistance. They may have chronic conditions which threaten their independence but not their lives.

These conditions include arthritis, hypertension, heart conditions, and hearing disorders. About 41 percent of people age 65 to 74 and 53 percent of the people age 75 and over had some limitation in activity due to chronic conditions. But only 15 percent of the younger group and 22 percent of the older were unable to carry on any major activity. Most of the group with a limitation could remain independent, provided that they had some assistance.

In 1985, about 5.2 million senior citizens required some assistance to maintain their independence. The assistance needed falls into different categories. Less than half need assistance in some or all basic physical activities, sometimes called activities of daily living. This category includes getting in and out of bed, dressing, eating, bathing, and using toilet facilities.

A slightly larger group needs assistance with home management activities, also called instrumental activities of daily living. These include shopping and cooking and some cleaning help.

Many of these older Americans receive assistance in their homes primarily from families and friends. The 1984 National Health Interview Survey found that nearly one-third of the people age 65 and over who were living in the community had trouble with the basic physical or home management activities.

However, only about a quarter of the over-65 population received assistance with these activities. This means that nearly ten percent of the over-65 population needs help at home and is not receiving it.

My proposal, which is based on a recommendation of the National Governors Association and supported by the National Council of Senior Citizens, would authorize a program of grants to provide these much-needed in-home services.

The services will help many older Americans to continue living in their homes or in the homes of others without having to give up their independence by going into a nursing home. The services also will assist families and friends who already provide much of this help just to get a respite or a helping hand.

Many of the health problems of senior citizens, as well as the rest of us, can be avoided or kept in check by early detection. Preventive medicine is the most cost effective medicine. However, many people do not have routine checkups or health screens.

There are a variety of explanations for this, including the fact that Medicare and many other health insurance plans do not pay for these routine services. Also, physicians are not readily accessible in many areas.

My proposal would authorize grants for preventive health services to be provided at senior citizens centers or other sites. These services would be provided periodically, perhaps three or four times a year. Perhaps a health fair format would be used, providing informal health education as well as examinations and screenings.

These screenings should identify the early stages of diseases and disabling conditions so that the individual can receive timely treatment and advice from physicians. The proposal specifically excludes services which would be already paid for by Medicare. Priority in services would be given to areas which are medically underserved and which have a concentration of economically needy individuals.

Mr. Chairman, I commend you for your leadership in the field of services for older Americans. I hope that you will consider my proposals as you move ahead with the reauthorization of the OAA. I and, of course, my staff stand ready to work with you or your staff on these issues.

Senator MATSUNAGA. Thank you very much, Senator Lautenberg. The Subcommittee will indeed take into serious consideration your proposals.

Senator LAUTENBERG. Thank you very much.

Senator MATSUNAGA. We would be happy now to hear from Senator Graham.

Senator LAUTENBERG. Excuse me, Senator. Thank you very much, Mr. Chairman.

Senator GRAHAM. Thank you, Mr. Chairman, and I wish to join in the remarks that have just been made by Senator Lautenberg which are very similar in their direction to those that I would like to share.

I have submitted for the record a fuller statement, Mr. Chairman, and would like to summarize in the time available.

Senator MATSUNAGA. Without objection, your statement will appear in full in the record, and we would be happy to hear your summary.

Senator GRAHAM. As Senator Lautenberg has stated and as my written statement elaborates our experience in Florida, the Older Americans Act is an act of Congress which has led to many successes, successes in improving the quality of life of older Americans.

This period now of reauthorization of the Older Americans Act affords us the opportunity to build upon those successes, to build upon them so that we can provide a program that will provide an even better future for older Americans.

I suggest, Mr. Chairman, that that better future would be characterized by the following: first, a renewed, sustained and serious emphasis on wellness—wellness, as distinct from accepting the inevitability of illness and crisis intervention; second, the application in a systematic way of many of the early intervention and preventive measures that have demonstrated enough success to now be worthy of expansion; third, utilization of community resources; fourth, the integration of the concepts of the Older Americans Act and Medicare through a coherent federal program to maintain the highest possible state of good health and quality of life for older Americans.

Our State of Florida has served somewhat as a laboratory. We do this because of the large number of older citizens who are residents of our State, Mr. Chairman. We also do it because of the many examples of programs which have worked successfully in our State, as they have in others.

There are issues in the Older Americans Act which Floridians are particularly sensitive to and which I would like to emphasize today. We should review and revise the distribution of surplus commodities to senior programs so nutritional needs can be better met and so food does not go to waste while entangled in federal regulations.

We should continue support services to caregivers. In this written statement I have submitted, I have given examples of the effective use of that aid to caregivers, so that they and the people to whom they give care can remain in their homes and communities.

We should give States more flexibility in developing and implementing social service programs and allocating resources. Often, agencies at the State level have a better feel for the needs of the elderly they serve and can avoid costly duplication of services or unnecessary expenditures.

We should promote inter-generational projects under the Older Americans Act. An example would be a day care facility in which senior participants were actively involved with the children. The emotional dividends from such interaction are measureless for both groups.

We should begin development under the OAA of a data gathering system which would ultimately yield a quality model for managing health care delivery systems.

In bringing increased coherence to the Older Americans Act and the Medicare program, I would urge the following changes. In the Older Americans Act, I propose the addition of a title under which grants would be made available to participating States for the development of community care preventive health care programs for the elderly. This program, Mr. Chairman, has been very successful in our State. This year, over 40,000 older Floridians will be served under Florida's Community Care for the Elderly Program.

The types of services which I hope would be provided through such a stimulation of a federal-State collaborative effort to bring services into the communities, into the homes, to use community-based resources would include nutritional counseling, exercise and physical therapy programs, screening home environments to control preventable injury, and screening for mental health and medical problems.

I am suggesting, Mr. Chairman, that although this is in the jurisdiction of other committees of the Congress that we look at the Medicare program and the older Americans program as being two of the tactical means by which we can accomplish the common purpose of a high state of wellness for older Americans.

Towards this end, I would propose the following additions to the Medicare program: one, an annual preventive health care checkup, to include a routine physical examination and screening for medical and mental health problems; two, immunization for high-risk Medicare beneficiaries against infectious diseases; three, provision of prescription medications to Medicare beneficiaries for certain medicines for limited chronic diseases, such as hypertension, diabetes, arthritis, certain forms of depression, and other identified illnesses; four, Medicare premium discounts to those beneficiaries who follow a healthy lifestyle to provide an added incentive for personal wellness responsibility.

Mr. Chairman, I urge you and this Subcommittee to consider that as America's population ages, we need to make use of the talent and vitality of all of our citizens. We cannot be a nation obsessed with progressive degeneration, but rather a population motivated to prevent disease and reduce illness.

We must deal with catastrophic health crises; we must deal with long-term health care. But we also must deal with the prevention which can minimize those tragedies and with the quality of life we deserve to have as we age.

Thank you, Mr. Chairman.

[The prepared statement of Senator Graham follows:]

SENATOR GRAHAM'S TESTIMONY
BEFORE THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

Thursday, April 30, 1987 Washington, D.C.

GOOD MORNING MR. CHAIRMAN, DISTINGUISHED MEMBERS OF THE COMMITTEE:

Reauthorization of the Older Americans Act affords us the opportunity to build upon the successes we have had under this program to an even better future for older Americans.

That better future would be characterized by:
FIRST: a renewed, sustained and serious emphasis on wellness as distinct from accepting the inevitability of illness and crisis intervention.
SECOND: the application in a systemic way of some of the early intervention and preventive measures that have demonstrated enough success to be worthy of expansion.
THIRD: utilization of community resources.
FOURTH: the integration of the concepts of the Older Americans Act and Medicare through a coherent federal program to maintain the highest possible state of good health and quality of life for older Americans.

Our state of Florida has served somewhat as a laboratory for this because of the large number of older citizens that we have. There are many examples of how programs are successfully working in our state, as in most others. My written statement gives several such examples.

There are issues in Title III of the Older Americans Act which Floridians are particularly sensitive to and I'd like to emphasize those today.

- We should review and revise the distribution of surplus commodities to senior feeding programs so nutritional needs can be better met and so food does not go to waste entangled in federal regulations.
- We should continue support services to caregivers like Mrs. Butler so that they and the people they care for can remain in their homes and communities.
- We should give states more flexibility in developing and implementing social services programs and allocating resources. Often agencies at the state level have a better feel for the needs of the elderly they serve and can avoid costly duplication of services or unnecessary expenditures.

- We should promote intergenerational projects under the OAA. An example would be a day care facility in which the senior participants were actively involved with the children. The emotional dividends from such interaction are measureless for both groups.
- We should begin development, under the OAA, of a data gathering system which would ultimately yield a quality model for managing health delivery systems.

In bringing some increased coherence to the Older Americans Act and the Medicare program, I will be urging some of the following changes in the Medicare program which will complement and facilitate our wellness objectives:

1. An annual preventive health care check-up to include a routine physical examination and screening for medical and menatl health problems.

2. Immunization for high risk Medicare beneficiaries against infectious diseases.

3. Provision of prescription medications to Medicare beneficiaries for certain medicines for limited chronic diseases such as: hypertension, diabetes, mellitus, arthritis, osteoporosis, certain forms of depression and other identified illnesses.

4. Medicare premium discounts to those beneficiaries who follow a healthy lifestyle as added incentive for personal wellness responsibility.

5. Community care preventive health programs for the elderly to include:
   nutritional counselling,
   exercise and physical therapy programs,
   screening home environments to control preventable injury
   and screening for mental health and medical problems.

I urge you to consider that as America's population ages, we need to make use of the talent and vitality of our older citizens. We cannot be a nation obsessed with progressive degenration -- but a population motivated to prevent disease and reduce illness.

We must deal with catastrophic health crises. We must deal with long term health care. But we must also deal with the prevention that can minimize those tragedies and with the quality of life we deserve to have as we age.

Senator MATSUNAGA. Thank you very much, Senator Graham. Certainly, your suggestions will be taken into serious consideration by the Subcommittee.

Senator GRAHAM. Thank you.

Senator MATSUNAGA. Thank you for taking time out of a busy day.

Before we proceed with the next panel of witnesses, I wish to remind all witnesses that we have a traffic signal system here, green, yellow and red, and when the green is on, of course, you are free to go. When the yellow comes on, you must go like hell and when the red comes on, it means stop, of course.

We do that in order that all witnesses may have a chance to testify, and then if any of the members of the Subcommittee have any questions, including those who are absent, we may ask questions of you. So I request that you, as much as possible, comply with the traffic signals here.

Our next panel of witnesses consists of representatives of two Executive Branch agencies which have responsibility for administering portions of the Older Americans Act: Mr. Roberts T. Jones, who is the Deputy Assistant Secretary of Labor for the Employment and Training Administration. The Department of Labor administers Title V, the Community Service Employment Program of the Older Americans Act. Accompanying Mr. Jones is Mr. Paul Mayrand, Director of the Office of Special Targeted Programs.

We also have Ms. Sonia Crow, who is the Associate Administrator for Food and Nutrition at the Department of Agriculture. The Department of Agriculture, as you know, is responsible for distributing excess commodities or the cash equivalent to States under Title III-C of the nutrition program. Accompanying Ms. Crow is Mr. Stanley Garnett, the Assistant Deputy Administrator of Special Nutrition Programs.

Mr. Jones, we will be happy to hear from you.

STATEMENTS OF ROBERT T. JONES, DEPUTY ASSISTANT SECRETARY OF LABOR, EMPLOYMENT AND TRAINING ADMINISTRATION, U.S. DEPARTMENT OF LABOR, ACCOMPANIED BY PAUL MAYRAND, OFFICE OF SPECIAL TARGETED PROGRAMS; AND SONIA F. CROW, ASSOCIATE ADMINISTRATOR, FOOD AND NUTRITION SERVICE, U.S. DEPARTMENT OF AGRICULTURE, ACCOMPANIED BY STANLEY GARNETT, ASSISTANT DEPUTY ADMINISTRATOR, SPECIAL NUTRITION PROGRAMS

Mr. JONES. Mr. Chairman, thank you very much. We would be pleased to submit our statement for the record and summarize it.

Senator MATSUNAGA. Your written statement, as presented, will appear in full as though presented and your summary would be very much appreciated.

Mr. JONES. Mr. Chairman, we appreciate very much this opportunity to appear before you today to discuss the Department of Labor's activities under Title V of the Older Americans Act and our future plans for this program.

Accompanying me today is Mr. Paul Mayrand, Director of the Office of Special Targeted Programs, who has responsibility for Title V.

As you know, the authorization of appropriations for this program expires at the end of this fiscal year. The Administration is proposing a three-year extension of the authorization through fiscal year 1990.

We are not proposing any substantive changes in the legislation. However, we will propose a few technical changes, principally to update references to other legislation and agencies.

I would like first to outline the current scope of the Title V program, also known as the Senior Community Service Employment Program (SCSEP). This program employs elderly, low-income persons in part-time community service jobs. All program participants are 55 or older. Participants work an average of 20 hours a week and are employed in a variety of community services activities, such as health care, home repair, day care, and beautification, conservation and restoration efforts.

Seventy-seven percent of the participants are age 60 or older, and nearly half are 65 or older. Over sixty-seven percent are female and over half have not completed high school, and about 85 percent have a family income below the poverty level.

At the present time, the Senior Community Service Employment Program supports 61,000 job opportunities, funded at the level of $312 million for the 12-month period that ends June 30, 1987.

We will begin spending the currently appropriated fiscal 1987 appropriation of $326 million on July 1, which will fund approximately 63,800 job opportunities. We have proposed to continue this level in 1988.

Over the years, increasing efforts have been made to move program participants directly into unsubsidized jobs, primarily in the private sector. As a result, progressively more workers are being placed into regular jobs, with the rate increasing from 11 percent in 1981 to over 20 percent in 1986. Also, the Department of Labor and the Department of Health and Human Services jointly funded the National Center on Black Aged to test new approaches to preparing older workers for placement into private sector jobs. Recently, we awarded a grant to the National Council on Aging to promote the employment of older workers, particularly in the private sector.

The Title V program is administered in part by national organizations and in part through State grants. Appropriations language for program year 1987 has reserved 78 percent of the amount appropriated for Title V for eight national organizations. Three of these operate primarily in rural areas—Green Thumb, the U.S. Forest Service, and the National Center on Black Aged.

The National Urban League operates primarily in cities, while the National Council of Senior Citizens, the American Association of Retired Persons, the National Council on Aging, and the National Association of Hispanic Elderly operate mainly in urban areas. The remaining 22 percent of the funds is provided to the States.

A recent evaluation of this program funded by the Department identified a very high degree of program satisfaction among enrollees and agencies where they work. This is consistent with previous evaluations which found SCSEP meeting its legislative objectives.

The Department also has completed a study of the unit cost used in budgeting for the Title V program. This study was undertaken at the request of the Congress to determine whether adjustments should be made in the unit cost, which has not been changed since 1981.

As a result of this study, the Department determined that the unit cost is adequate for the foreseeable future.

Mr. Chairman, as you know, the older worker program is not the only DOL-funded training and employment program that serves older Americans. The Job Training Partnership Act (JTPA) authorizes training and placement of economically disadvantaged older individuals in employment opportunities with private business concerns.

They are eligible for and receive training and employment services under the Title II-A general grant to the States and the Title III program for dislocated workers. Moreover, three percent of the funds for each State's JTPA training programs is reserved for this purpose. This amounts to approximately $55 million for the program year beginning July 1, 1987.

In summary, the SCSEP is an effective program, simple in design and execution, but flexible enough to meet the needs of enrollees and the communities. We hope the Committee will consider this extension.

Thank you.

[The prepared statement of Mr. Jones follows:]

STATEMENT OF
ROBERTS T. JONES
BEFORE THE
SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

April 30, 1987

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to appear before you today to discuss the Department of Labor's (DOL) activities under Title V of the Older Americans Act and our future plans for this program. Accompanying me today is Paul A. Mayrand of our Office of Special Targeted Programs, which administers the Title V program.

As you know, the authorization for appropriations for this program expires at the end of this fiscal year. The Administration is proposing a 3-year extension of the authorization through Fiscal Year (FY) 1990. We are not proposing any substantive changes in the legislation: however, we will propose a few technical changes principally to update references to other legislation and agencies.

I would like, first, to outline the current scope of the Title V program, also known as the Senior Community Service Employment Program (SCSEP), and then discuss other older worker activities.

The SCSEP employs elderly, low-income persons in part-time community service jobs. All program participants are age 55 or older. Participants work an average of 20 hours a week and are employed in a variety of community service activities such as health care, home repair and day care as well as in beautification, conservation and restoration efforts. They work in schools, hospitals, parks, community centers, and other government and private nonprofit facilities. The participants are paid an average hourly wage of $3.45 in these community service jobs.

The SCSEP also provides participants with personal and job-related counseling, annual physical examinations, job training, and, in many cases, referral to regular jobs in the competitive labor market.

Over three-fourths of SCSEP participants are age 60 or older, and nearly half are 65 or older. Over 67 percent are female, over half have not completed high school, and about 85 percent have a family income below the poverty level.

At the present time, the SCSEP program supports 61,000 job opportunities and is funded at the level of $312 million for the 12-month period that ends on June 30, 1987. We will begin spending the currently-appropriated FY 1987 appropriation of $326 million on July 1, 1987, which will fund approximately 63,800 job opportunities. We have proposed to continue this level in FY 1988.

In the past few years, efforts have been made to move program participants into unsubsidized jobs, primarily jobs in the private sector. As a result of this effort, progressively more workers are being placed into regular jobs, with the rate increasing from 11 percent placed in 1981, to over 20 percent in 1986. As a part of our effort to move participants into private sector jobs, the Department of Labor and the Department of Health and Human Services jointly funded the National Center on Black Aged to test new approaches to preparing older workers for placement into private sector jobs. The experience and knowledge gained from these projects will lead to improvement in the transition of participants into private sector jobs.

The Title V program is administered in part by national organizations, and in part through State grants. Appropriations language for Program Year 1987 has reserved 78 percent of the amount appropriated for Title V for eight national organizations. Three of these operate primarily in rural areas--Green Thumb, Inc., the U.S. Forest Service, and the National Center on Black Aged. The National Urban League operates primarily in cities, while the National Council of Senior Citizens, the American Association of Retired Persons, the National Council on Aging, and the National Association for Hispanic Elderly operate mainly in urban and suburban areas, and in a few rural areas. Local projects may be operated through contracts with State or local nonprofit organizations such as agencies on aging or community groups, and through local affiliates of the national organizations. The remaining 22 percent of the funds is provided to States. These State grant funds are generally administered by the various State agencies on aging.

A recent evaluation of this program by a private research firm identified a very high degree of program satisfaction among enrollees and the agencies where they work. This finding is consistent with previous evaluations which found the SCSEP meeting its legislative objectives.

The Department also has completed a study of the unit cost used in budgeting for the Title V program. This study was undertaken at the request of the Congress to determine whether adjustments should be made in that unit cost which has not been changed since 1981. Let me summarize briefly the results of our study. To assess changes in program expenditures over the past five years, we reviewed detailed information provided by our national sponsors and compared the data for 1981 and 1986. While the data showed sponsors made adjustments in some spending areas for inflation and programmatic purposes, the actual service year cost for the program year ending June 30, 1986, was approximately $4,800, or some $311 per service year below the current unit cost of $5,111 which is used for planning and budgetary purposes. As a result of this study, the Department has determined that the unit cost is adequate for the foreseeable future. Because of the gap between the actual and budgeted cost of positions, we may be able to totally or partially offset cost increases without compensatory increases in the appropriation.

Mr. Chairman, as you know, the SCSEP in not the only DOL funded training and employment program that serves older Americans. The Job Training Partnership Act (JTPA) authorizes training and placement of economically disadvantaged older individuals in employment opportunities with private business concerns. They are eligible for and receive training and employment services under the Title II-A general grant to the States and the Title III program for dislocated workers. Moreover, three percent of each State's training grant allotment under Title II-A of JTPA is reserved for this purpose. This amounts to approximately $55 million for the program year beginning July 1, 1987. The Administration's proposed $980 million workers readjustment assistance program will also serve older workers.

We are requiring the SCSEP sponsors to coordinate their programs closely with other employment programs, particularly the JTPA. This makes the SCSEP program available to more people through the movement of SCSEP enrollees into JTPA training positions. It permits these enrollees to develop new skills through classroom instruction and other formal training situations. After the training, they are able to find unsubsidized jobs in the private sector. Over 1,600 SCSEP enrollees have participated in JTPA and many have been placed into full-time jobs. At the present time, there are over 240 JTPA-SCSEP related agreements. We believe it is important to effectively utilize all of the Department's available resources on behalf of older workers, and we will continue to strongly encourage close program coordination. We intend to continue to work closely with SCSEP sponsors to ensure progress in their coordination efforts.

Identifying the needs of the workforce and developing appropriate solutions will become increasingly important if this Nation is to compete successfully in international commerce. Bureau of Labor Statistics projections indicate that prime age workers will constitute a larger share of the labor force in the years ahead, and the average age of the workforce will rise. With fewer young workers entering the labor force between now and the turn of the century, older workers will become a particularly valuable resource. To take advantage of this resource, retraining of the older worker will become more important. This retraining will impact on the older worker as well as other workers. Consequently, the practical experience that we have gained with older workers under the SCSEP and JTPA will form the foundation upon which future training and employment policies will be based.

In summary, the SCSEP is an effective program, simple in design and execution, but flexible enough to meet the needs of enrollees and their communities. We hope through emphasis on coordination and unsubsidized placement, as well as effective management, to make the program even more effective in serving eligible persons.

Thank you, Mr. Chairman. This concludes my prepared statement. We will be pleased to answer any questions that you or other Members of the Subcommittee may have.

Senator MATSUNAGA. Thank you very much, Mr. Jones.

We would be happy to hear from you now, Ms. Crow.

Ms. CROW. Thank you very much, Mr. Chairman. We appreciate the opportunity to discuss USDA's role in contributing to the nutritional well-being of elder Americans.

In recognition of the sincerity of that red light, I would like to summarize briefly my testimony for you today.

As you mentioned earlier, USDA's role in the nutrition program for the elderly is limited solely to providing commodities or cash in lieu of commodities for meals served according to a set rate of reimbursement which is specified in the Older Americans Act.

When the NPE program started a number of years ago, it served as an important outlet for USDA's price support and surplus removal activities. It aided older Americans by providing them with quality commodities for use in the NPE program and, of course, it was of assistance to our American farmers.

Over time, however, as the States had the opportunity to receive cash instead of commodities, the direct link to the farm programs became somewhat attenuated. Today about 96 percent of the support provided by USDA is in the form of cash rather than in the form of commodities.

At USDA, we think it is very important to try to reverse this trend and to bring back a better balance between cash in the program and the use of commodities. Certainly, in your considerations for reauthorization of the Older Americans Act, there will be many discussions of funding under the Act, and we think it is important for everyone to keep in mind that the use of USDA commodities is an important and attractive way to stretch food dollars.

USDA commodities are anywhere from 10 to 15 percent less expensive in terms of use by local project sites than if purchased commercially. In some instances, depending on the product, that savings can be as much as 35 percent—a terrific and important way to stretch your food dollar. In addition, the use of commodities has the direct benefit of assisting our American farmers.

In order to promote greater use of commodities in the NPE program, USDA last year provided an extra incentive to States. Now, if a State accepts just 20 percent of its NPE support in the form of commodities—and formerly, Mr. Chairman, our threshold level was 50 percent—then that State becomes eligible for a wide variety of "bonus" or basically free commodities in addition to the commodities that they receive under their NPE support levels.

These bonus commodities are very fine products. They currently include ground beef, a wide variety of fruits and vegetables, flour and a lot of other very good things. A number of States have taken us up on this offer. We are pleased to say that Hawaii is one of them, and we hope that they have had a good experience with the use of USDA commodities. We believe that they have.

The second important initiative that USDA has in connection with the NPE program is our initiative to simplify program funding by providing States a fixed yearly grant in place of the current per-meal reimbursement rate.

Although funding is made available under the Act on a per-meal basis, the Secretary of Agriculture, by law, cannot provide States with more funds than are appropriated. Since the final reimbursement rate per meal up to the rate specified in the Act cannot be calculated until the total number of meals served during the year is reported by the States, the Department cannot announce and the States and the local providers cannot know with any certainty the final per-meal rate until months after the end of the fiscal year. This funding process promotes uncertainty at all levels.

The best example that I can provide to the Committee, perhaps it is more appropriate to call it the worst example, is the funding cycle that we went through in fiscal year 1985. In that year, the Department had to announce, in accordance with the law, four different rates, and the local providers, as it turned out, could not be given the final per-meal reimbursement rate until February of 1987.

Obviously, such uncertainty was particularly apparent in 1985, but under the current funding mechanism this could occur in any given fiscal year. In order to rectify this situation, the Department has recently submitted to Congress a draft bill to change this funding process.

Since I have got a yellow light now, I am going to have to speed up here. Basically, what we are doing is suggesting that we turn the per-meal reimbursement rate into a fixed yearly grant and then, based on the amount that would be appropriated, each State would receive its proportionate share of the grant depending on the number of meals that were served in the preceding fiscal year. We think this process would add a great deal of certainty to the program and would be a benefit to all of the people at all levels. We hope that you give this very serious consideration.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Crow follows.]

TESTIMONY OF SONIA F. CROW
ASSOCIATE ADMINISTRATOR
FOOD AND NUTRITION SERVICE
U.S. DEPARTMENT OF AGRICULTURE
BEFORE THE
SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE
APRIL 30, 1987

Thank you for your invitation to appear today to discuss the role played by USDA in contributing to the nutritional well - being of older Americans pursuant to the provisions of the Older Americans Act. I am pleased to be a part of this hearing and will attempt to describe our efforts in this important area of program activity.

At the outset, I need to emphasize that the role USDA presently plays in the Nutrition Program for the Elderly (NPE) is limited solely to providing commodities or cash in lieu of commodities for meals served according to a set rate of reimbursement specified in the Older Americans Act.

The amount of food or cash that USDA gives each State is based on the number of meals served in the program and the level of assistance per meal authorized by legislation. USDA will be able to subsidize 241 million meals this year.

USDA has no involvement in operating or managing the Nutrition Program for the Elderly. It makes policy decisions only related to meal reimbursement. The Administration on Aging (AOA) of the Department of Health and Human Services (DHHS) holds the primary responsibility for this program and is in a more authoritative position to gauge results and successes. However, as funding is an important component of any program, I would like to turn now to USDA's role in the NPE.

When USDA first became involved with the Nutrition Program for the Elderly, the program was an outlet for surplus foods and price-support commodities, much like the school lunch progam. As the years passed, however, legislation was modified to allow cash in lieu of commodities and gradually most States have chosen to receive subsidies in cash rather than in commodities. Today about 95 percent of our contribution is in the form of cash.

Grant Proposal

On March 24, 1987, the Department delivered to the Congress a draft bill to simplify program funding through the use of a fixed yearly grant. The bill would establish a procedure whereby each State would receive annually a proportionate share of funds appropriated for the NPE. Each State's share would be based on the number of meals served within the State under Titles III and VI of the Older Americans Act during the preceding fiscal year.

We believe that the proposed bill would result in major improvements in the program. State and local agencies would know at the beginning of the year how much funding they would receive for the year. The authorized funding levels in the proposed legislation reflect projected food cost inflation. These changes would assure a more efficiently run program, since program operators would be able to plan in advance based on a stable funding level. The bill also would eliminate the confusion which has resulted in the past when it has been necessary to adjust the per meal rate during and after the end of the fiscal year. This situation occurs because although the NPE is an annually appropriated program, each meal providers' total program share can be severly affected by the funding distribution mechanism required under current NPE law. Within the States, there is a reimbursement rate set for meals that is increased each year to account for inflation, and every meal served receives the per meal subsidy. However, if the number of meals served times the reimbursement rate exceeds the funds available, then the Department must reduce the per meal subsidy so that all meals served are reimbursed at the same level. An example of the funding problems created is best illustrated by our Fiscal Year 1985 experience. In that year, the Department, in accordance with law, had to announce four different reimbursement rates.

The original "authorized" per meal rate was 58.75 cents based on inflating the previous year's rate for the CPI for food away from home. In February of 1985, FNS announced a per meal rate reduction to 56.76 cents. This was due to an estimate of 212.8 million meals and an appropriation of $120.8 million. Later that year, a revised estimate of 225 million meals, about a 12 million increase, caused the per meal rate to be adjusted again. It was reduced to 53.61 cents. Finally, in early 1986, the Older Americans Act Amendments were passed setting the Fiscal Year 1985, 1986, and 1987 per meal reimbursement rates at 56.76 cents. This example shows clearly how a yearly fixed grant would help to alleviate this kind of confusion.

The concept of a grant is nothing new to the States since other AOA programs are funded in this manner. In response to local agencies' concerns, our proposal clarifies that the entire grant must be passed through to local agencies as meal support to ensure that the funds are not used for other Title III or VI programs. A grant will not change the way that food is distributed at the local level, and providers will not need to change the way that they provide meals. Only the method of distributing appropriated funds will be different. Commodity usage flexibility will be maintained because States will still be able to obtain all or part of their grant in the form of commodities.

Increased Use of Commodities

While advocating the need for a yearly fixed grant, we have also initiated efforts to increase the use of commodities in NPE. The Department's rules with respect to commodity usage is more liberal than at any other time.

Last year, the Department announced a change in policy with respect to the availability of bonus commodities to the NPE. Bonus commodities are those surplus and price-support commodities which the Department offers to a State at no cost for use in feeding programs. All states are eligible to receive bonus dairy products. Previously, only States electing to receive 50 percent of their NPE support in the form of commodities were eligible to receive bonus commodities other than dairy products. Under the Department's new policy, if a State agrees to take just 20 percent of its NPE support in the form of commodities, it may order the full range of bonus commodities, not just bonus dairy products. Such commodities currently include ground and canned beef, as well as flour and various fruit, vegetable and poultry items as they are available.

In addition to this policy change, USDA is proposing to enter into an agreement with the National Association of Nutrition and Aging Services Programs (NANASP) to encourage elderly congregate feeding sites to use commodities. Under the agreement, NANASP will hold seven conferences across the country to demonstrate the quality and benefits of USDA commodities. We believe this effort will encourage providers to seek more commodities as they learn more about the benefits they get from using commodities.

Conclusion

In conclusion, USDA is proud of its role in helping to meet the nutritional needs of older Americans under the Older Americans Act. We believe it is imperative that more commodities be utilized to merge the vital objectives of helping farmers and providing nutritious meals for the elderly, that a grant be instituted to simplify the program, and that we continue to strive to give the States the flexibility they need in obtaining commodities.

That concludes my remarks, Mr. Chairman. I shall be pleased to respond to any questions.

Senator MATSUNAGA. Thank you very much, Ms. Crow.

Now, Mr. Jones, the Act now allows the Department to provide a waiver of the administrative cost cap in cases where the Title V sponsor can demonstrate it cannot meet the cap requirement.

How many waivers were requested and approval denied for the current program year? Do you have any such figures?

Mr. JONES. I believe last year, Mr. Chairman, we had four, one was accepted and three were rejected.

Senator MATSUNAGA. I see, and what would be your estimate of the number of waiver requests the Department will receive when the cost cap is lowered to 12 percent during the next program year?

Mr. JONES. For the next program year we have received about nine requests; none have been acted on at this point. You might be interested to know that the administrative costs for each of those six program years from 1980 to 1985 has run between 10.4 percent and 11.1 percent. These are average costs across the system and if they so continue, we would expect only to see a few number of waiver requests primarily from rural or very small programs that have basically higher costs per unit. This could be expected even at the 12-percent level.

Senator MATSUNAGA. Well, as you probably know, a number of concerned organizations have suggested an increase back to the original 15 percent. Do you find this necessary or do you feel that 12 percent would be sufficient?

Mr. JONES. No, Mr. Chairman. I think there is very little evidence that 15 percent is needed. As I indicated, our averages for the past five or six years have run between 10 to 11 percent.

I believe some organizations have requested that administrative costs be stabilized at the current 13.5 percent. There certainly might be a better case for doing that than there would be for 15 percent. I would see no need for going back to 15 percent.

Senator MATSUNAGA. Then you would have no objection to raising it to 13.5 percent?

Mr. JONES. We would not raise any objection to that, Mr. Chairman. As you recall, this issue was not in the first place brought about by the Department. We think that these ranges are not inappropriate, and are consistent with other programs that we have underway.

Senator MATSUNAGA. Now, as I understand it, the Department has authority to conduct experimental projects for second career training and placement in private business. How would you evaluate the experience gained by those national organizations and States which have operated experimental projects?

Mr. JONES. Very good, Mr. Chairman. That experiment has been underway, and I am trying to find the information here on it. We would be happy to submit it for the Committee. Our experience has been and continues to be that this population of people is generally assumed to be difficult to place into private sector jobs. However, there is tremendous opportunity to find them jobs in the private sector, particularly as the labor market begins to tighten.

This would include part-time jobs and alternate work hours and situations that will accommodate older worker concerns. There has been great success in that experiment.

There have been about 219 projects with about 2,800 individuals in them so far, and we will provide you with a copy of the evaluation of that effort, done for the Department by Centaur Associates, Inc.

Senator **Matsunaga**. We would appreciate that, if you could present it for the record.

[A copy of the Centaur Associates, Inc. report submitted for the Committee's review, follows:]

REPORT ON THE 502(e)
EXPERIMENTAL PROJECTS
FUNDED UNDER TITLE V
OF THE OLDER AMERICAN ACT

Contract No. 99-5-3333-77-021-01

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Washington, D.C.
July, 1986

EXECUTIVE SUMMARY

Introduction

This report provides a basic description and analysis of the experimental projects funded under Title V of the Older Americans Act, as amended. Information for this report was collected in conjunction with field work conducted for a nationwide evaluation of the Senior Community Services Employment Program (SCSEP).

Experimental projects are intended to provide employment opportunities for older workers in the private sector. Funding for the experimental projects are contained in the basic SCSEP allocation. No additional funds were allocated for experimental project operation. Grantees interested in conducting experimental projects are directed to do so while maintaining their current level of authorized slots under SCSEP.

Overview of the Experimental Projects and Project Participants

The experimental initiative first was implemented in January of 1983. Between that time and July of 1986, approximately 219 experimental projects have been conducted. Of this total, 132 are new projects and 87 are projects that were continued from prior years. All national sponsors and 11 states have conducted experimental projects at one time or another since the program was initiated.

Between January, 1983 and June 30, 1985, approximately 2,800 individuals entered experimental projects. Slightly over one-half of these (55 percent) have been placed in unsubsidized jobs in the private sector.

Older worker participants in experimental projects are primarily recruited from outside the population of SCSEP enrollees. Experimental project participants tend to be younger and better educated than SCSEP enrollees. Experimental projects also tend to include higher proportions of females and whites than SCSEP.

Project Design and Employer Participation

Most local experimental projects are designed simply. At the onset of the project, steps are taken to determine the needs of employers in the project area. Once these needs are identified, older workers are recruited to address the needs.

Employer needs generally are identified in two ways. The first method used by many experimental projects has been to create an advisory committee to assist staff in analyzing the local labor market. A second method used by local projects is to make direct personal contact with employers in the private sector, identify their demand for employee skills, and secure their commitment to hire an older worker through the program.

Securing employer commitment to participate in experimental projects has been time-consuming. Experimental project operators have encountered age discrimination and distrust of government programs among private sector employers. These impediments have been countered through publicity, testimonials by advisory committee members, face-to-face contact with employers and simplification of the procedures required for involvement in the program.

Overall, the majority of employers that have participated in experimental projects are small to medium-sized firms. Personal contact appears to have been very important in soliciting the involvement of private sector employers in the experimental projects.

Training Provided Under Experimental Projects

The experimental projects have provided four basic types of services: classroom training, work experience, on-the-job training, and transitional services. Training under the experimental projects has been concentrated in health and clerical occupational areas.

Classroom training has been provided to a larger proportion of participants in experimental projects than any other single form of training. On-the-job training has been increasing in popularity among the experimental projects, possibly reflecting an increased willingness of private sector employers to commit to the projects.

Many participants in experimental projects receive more than one type of training, such as a combination of classroom training and work experience. Many also receive transitional services such as job clubs and work readiness programs.

Costs of Experimental Projects

Experimental project costs per participant were relatively stable in the two program years of the experimental projects. In the third program year, project costs per participant and per placement dropped. Project ccosts per participant were $887 in the first program year, $986 in the second program year, and $616 in the third year. Project costs per placement were about $1,600 PY 1983 and PY 1983-83. Costs per placement fell about 30 percent to approximately $1,100 in PY 1984-85. Project costs per participant and per placement have declined as sponsors have gained more experience in conducting experimental projects.

Significant Accomplishments

The accomplishments of the experimental projects fall into four broad categories.

- The experimental projects have opened up private sector opportunities for placement of older workers, including both SCSEP ineligibles and SCSEP enrollees.

Experimental project operators have found that the most significant single accomplishment of their experience with experimental projects has been the increased understanding gained of the factors involved in placing older workers in occupations in the private sector. Further, a considerable amount of the experience gained in private sector placement has proved to be relevant to SCSEP efforts to secure unsubsidized placement for enrollees.

- The experimental projects have increased the visibility of the SCSEP projects in the community.

Many experimental project operators have found that the exposure their projects gained in the private sector has had a positive impact on their local SCSEP operations. For example, it is believed by some project operators that the local climate for hiring older workers has been improved by their implementation of experimental projects.

- The experimental projects have expanded the services of local projects to a broader base of older workers.

Many project operators view their experimental projects as a complement to their basic SCSEP operations. The experimental projects are seen as serving those most likely to succeed quickly in the private sector, while SCSEP operations focus on those who require more extensive training and supportive services. Accordingly, the experimental projects provided an opportunity for local SCSEP projects to serve a segment of the older worker population not eligible for SCSEP.

- The experimental projects have expanded the experience of local program operators with training techniques appropriate for older workers.

Most SCSEP projects place relatively little emphasis on formal training of SCSEP enrollees. The experimental projects have provided local project operators with an opportunity to gain additional experience with the various training techniques appropriate for older workers. In addition, the projects have increased the ability of local project operators to identify skills and credentials which will help older workers to improve their opportunities in the private sector.

Barriers to Program Success

Four major factors may have inhibited the success of the experimental projects. Some of these also may have discouraged some local projects from initiating experimental projects.

First, the experimental projects are not separately funded. Although local projects are allowed to divert funding from the SCSEP operations to conduct experimental projects, they are at the same time required to maintain their authorized SCSEP slot level. The lack of additional funding for experimental projects has made it difficult for local projects to allocate staff to experimental project operations.

Second, experimental projects place a significant burden on the administrative staff of SCSEP projects. It is estimated that basic administration and operation of an experimental project require about one person-year of effort per year. SCSEP projects have a median staff size of 2.5 persons, and a median Federal funding level of about $440 thousand. Accordingly, the demands of an experimental project can easily overwhelm the limited staff resources available at the local level.

A third factor which may have inhibited the success of the experimental projects has been the lack of dissemination of information among the projects. Since an initial meeting of experimental project operators in 1983, no subsequent inter-sponsor meetings of those involved in experimental projects have been held. As a result, little information exchange appears to occur among the operators of experimental projects.

The fourth major factor which may have inhibited the success of the experimental projects is the lack of recognition accorded local projects for conducting experimental projects or for implementing exemplary practices. Placements under the experimental projects do not count toward meeting placement goals under SCSEP. Although the inherent benefits of experimental projects are recognized by many local project operators, they have been discouraged by the lack of recognition from sponsors and from DOL for their experimental project accomplishments.

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1.0 INTRODUCTION AND SCOPE OF REPORT

This report reviews the experimental projects funded under Section 502(e) of Title V of the Older Americans Act, as amended. The projects started operation on January 1, 1983. Most of the information in this report relate to the first three program years of the experimental projects. Currently, the program is in its fourth year. The program years of the experimental projects cover the following periods:

PY 1983: January 1, 1983 - June 30, 1983
PY 1983-84: July 1, 1983 - June 30, 1984
PY 1984-85: July 1, 1984 - June 30, 1985
PY 1985-86: July 1, 1985 - June 30, 1986

The purpose of this report is to provide a basic description and analysis of the 502(e) experimental projects. During the first three program years, approximately 150 experimental projects were conducted. In the current year, PY 1985-86, 69 projects are being conducted. The projects have provided a mechanism for developing innovative approaches to placing older workers in occupations in the private sector. This report describes these efforts and summarizes findings from the experimental projects.

Information for this report was collected in conjunction with field work conducted for the review of local projects under the basic Senior Community Services Employment Program.[1] Ten local projects which had conducted 502(e) experimental projects were visited. In addition, representatives of state and national SCSEP sponsors provided information about their experiences with 502(e) experimental projects. Published reports and other documents were provided by the sponsors of experimental projects. Finally, round-table discussions were held with experimental project operators from two national sponsors.

The statistical data presented in this report are primarily based on the final Quarterly Progress Reports (QPR) available from sponsors of experimental projects during the study period. The QPRs provide information on the characteristics of the enrollees, the type of training undertaken and placements by type of occupation. However, QPRs were not available for all sponsors during the study period. Some QPRs were never submitted to DOL; some of these were not available from the sponsors of the projects.

As part of this study the first complete listing of all experimental projects conducted was compiled. Based on this listing (see Appendix A), detailed QPR data were available for approximately one-half of the experimental project sponsors in Program Year (PY) 1983, three-quarters in PY 1983-84, and 80 percent in PY 1984-85. Detailed QPR data were supplemented with reports and other data provided by DOL and the sponsors of experimental projects. Because data were not available for all experimental projects, the QPR data collected may not represent the universe of experimental projects. However, based on conversations with operators and sponsors of experimental projects, the QPR data, supplemented by other information collected for this report, appear to be adequate to indicate general characteristics and trends in the nationwide operation of the experimental projects.

---

[1] The results of this research are contained in a companion volume to this report. See, Centaur Associates Inc., "Report on the Senior Community Services Employment Program," prepared for the U.S. Department of Labor, draft, May 23, 1986. For the study of SCSEP nationwide, a sample of 40 local projects (in 39 locations) was visited between June and October, 1985. Ten of these local projects had conducted 502(e) experimental projects. During the field visits, semi-structured interviews were conducted with local project staff about their experiences with these experimental projects.

2.0 PROGRAM HISTORY

This chapter discusses the overall legislative and funding history of the 502(e) experimental projects. An overview is provided of the sponsors of experimental projects and the participation rates of national and state sponsors of these projects.

2.1 Purpose of the Legislation

The 502(e) experimental projects were first authorized in the Older Americans Act Amendments of 1978. The intent of Congress was reflected in the language of the legislation. Experimental projects were to focus on increasing older worker participation in the private sector, especially in high technology and high growth fields, by combinations of work-sharing, flexitime and other means to expand employment opportunities. Section 502(e)(1) of the Older Americans Act asks the Secretary of Labor "to conduct experimental programs that are designed to assure second career training and the placement of eligible individuals into employment opportunities with private business concerns."

In the Older Americans Act Amendments of 1981, the language of Section 502(e) was changed from permissive to mandatory. The Secretary of Labor was now directed to initiate experimental projects. Information on how to implement Section 502(e) was given to potential sponsors in Bulletin OW 82-13 and subsequent bulletins by the Division of Older Workers Programs, Office of Special Targeted Programs, Employment and Training Administration, U.S. Department of Labor. According to Bulletin OW 82-13:

> Section 502(e)(2) of the Older Americans Act suggests that activities under this part:
>
> > (A) Will involve different kinds of work modes, such as flexitime, job sharing and other arrangements relating to reduced physical exertion; and
> >
> > (B) will emphasize projects involving second careers and job placement and give consideration to placement in growth industries and in jobs reflecting new technological skills.
>
> Applicants are encouraged to be innovative in their approach and several innovative aspects may be utilized in a single project.

Sponsors submitting proposals to conduct experimental projects were to be judged on their intended linkage with the private sector, the types of training they were to offer and the innovativeness of their approach. The definition of innovation introduced in Bulletin OW 82-13 was expanded the next year in Bulletin OW 83-7:

> Sponsors should attempt to establish projects which are cost effective as well as innovative. Innovative projects may include those which are a departure from traditional ways of serving the elderly. The test for innovation must include consideration of the proposed project under the existing program guidelines. If

> it can be done within the normal Title V program, it can not be considered innovative.

Three years later, in Bulletin OW 86-9, the DOL listed a series of possible program approaches or activities that could be conducted by an experimental project, such as the targeting of specific industries that might have a variety of jobs and branches in other areas, such as grocery chains and banks.

2.2 Funding History

The amount of funds for entering into agreements under Section 502(e) to improve transition to private employment was specified in Section 506(a)(1)(b). Congress did not provide a separate appropriation for the experimental projects but rather specified the minimum and maximum amount of appropriated funds that could be spent on the projects. The annual amount was limited to at least one percent but no more than three percent of the excess amount for that year over the funds appropriated for fiscal year 1978 for the Senior Community Services Employment Program.

The first year of implementation for the experimental projects was Program Year 1983. Although Congress mandated the implementation of Section 502(e) in 1981, the funds for SCSEP are forward funded and the appropriations for 1981-1982 had already been made. The first realistic program year in which the experimental projects could be initiated was 1982-1983. However, there was uncertainty at that time about the future of the SCSEP program. Congress had appropriated funds only for the first three months of PY 1982-1983. The law required that the experimental projects be funded from the surplus of appropriations above the 1977-1978 level. Given only three months' appropriation for PY 1982-1983, the DOL determined there was no surplus available for experimental project implementation. In September, 1982 Congress made an appropriation for the remaining nine months of the program year. At that time, the DOL found that the funds in excess of the 1978 level were available to conduct experimental projects. A notice was sent to sponsors to submit applications to conduct experimental projects for the final six months of the program year.

The applications were accepted in November, 1982 and the first year ran for six months from January 1, 1983 to June 30, 1983. According to Bulletin OW 82-13:

> The implementing legislation permits nearly $2 million for the experimental projects. This was determined as follows: The total excess funds over the 1978 level equals $65.4 million and 3 percent of this amount is $1.962 million.

The DOL had the option of reducing allocations made to sponsors by up to $2,000,000 and to set up a fund for competitive awards for experimental projects. The competition could be open to existing sponsors and other interested groups. Because of the recognized expertise of SCSEP sponsors in older worker employment, the DOL decided to allocate the SCSEP funds as usual to SCSEP sponsors and to implement the experimental program on a selective basis after the funds had been allocated. Sponsors were invited to submit applications for approval to use part of their SCSEP allocations to fund experimental projects.

The DOL set aside $500,000 of the PY 1982-1983 allocation for the States to use for experimental projects and the balance for the national sponsors to apply to experimental projects. In the first year, national sponsors with large amounts of supplemental funds allocated for the final nine months of program year 1982-1983 were limited to $500,000 or one percent, whichever was less, for the first program year. Other national sponsors and state sponsors were allowed to use up to four percent of their nine month extension allocation or $25,000, whichever was greater. Bulletin OW 82-13 had two important reminders:

> All sponsors are reminded that these are not new dollars but simply an application for flexible use of existing funds. Also, sponsors must maintain their authorized slot level -- even while conducting the projects.

In the second program year of the experimental projects (July 1, 1983 to June 30, 1984) a total of up to $3.2 million was available for the experimental projects. In Bulletin OW 83-7, a funding formula for the 502(e) experimental projects was set forth. This formula continues to be followed to the present:

> Sponsors may use from 1 to 3 percent of the amount over their 1978 allocation for these projects. In preparing an application sponsors may follow the steps below to determine the maximum dollar level of their application proposal:
>
> > (1) Subtract the amount of the 1978 grant level from the upcoming grant level.
> >
> > (2) The resulting sum should be multiplied by .03. This is the maximum level.
> >
> > (3) The result found in number (2) above may then be divided by 3 which will result in the minimum level.
> >
> > Example: In 1978 the Massachusetts Department of Elder Affairs had a grant of $995,000, in 1984 this grant will be $1,578,502. The difference between the two years is $583,502. This figure multiplied by Experimental/Demonstration level .03 equals the maximum level of $17,505. The minimum is determined by dividing the result by 3, which is $5,835.
>
> If the sponsor finds the maximum level too small it may petition the Division of Older Workers for a higher level.

However, the petition would not be considered until after the experimental projects have been selected and their aggregate funding levels determined. A few sponsors have petitioned for and have been granted increased funding levels for their experimental projects.

The amount earmarked for the experimental projects for program year July 1, 1984 to June 30, 1985 remained the same as the previous program year -- $3.2 million -- due to the overall freeze on Title V authorization for PY 1985. The history of the maximum level of available funds for the experimental projects for each program year is summarized below:

Available Funds for 502(e) Experimental Projects

PY 1983	$2.0 million
PY 1983-84	$3.2 million
PY 1984-85	$3.2 million
PY 1985-86	$3.4 million
PY 1986-87	$3.0 million

2.3 Administration of the Experimental Projects

As administrator of the Senior Community Services Employment Program (SCSEP) funded under Title V of the Older Americans Act, the DOL also has responsibility for the administration of the 502(e) experimental projects. To provide direction and technical assistance to sponsors of the experimental projects the DOL has issued a series of Older Worker Bulletins. These bulletins have been used by the national and State sponsors as guides to instruct the experimental project operators on the types of projects allowed and the procedures to be followed. Most sponsors have also disseminated guidelines to their local project operators on procedures to follow in linking up with the private sector, types of occupations to consider, and reporting responsibilities.

Basic requirements for the administration of the experimental projects in terms of recruitment, assessment and work site assignment are similar between the experimental projects and the basic SCSEP program. However, eligibility requirements for the two programs are different. Essentially, experimental project participants may have a higher income than SCSEP participants. While SCSEP participants are required to have incomes at no greater than 125% of the poverty level, experimental project participants may qualify if they are at or under the intermediate level income as reported in the Bureau of Labor Statistics (BLS) Retired Couples Budget. The eligibility limit set by the BLS budget is about one-third or more higher than the SCSEP limit set using earnings at or below 125% of poverty. The DOL thus gave the experimental project sponsors two levels of eligibility: (1) At or below the BLS budget, but above 125% of poverty, or, (2) At or below 125% of poverty. Most sponsors use both eligibility standards.

Most national and State sponsors that participate in the 502(e) program select a limited number of local SCSEP projects to implement experimental projects. Some sponsors select these local projects on a competitive basis and issue Requests for Proposals to subcontractors interested in operating the experimental projects.

Due to the limited funding of the experimental projects, administrative and operational support for the projects at the local level is part of the responsibility of the regular SCSEP staff. Most national sponsors that participate in the 502(e) program have assigned one staff person at their headquarters office to coordinate the experimental project, this person is typically paid from funds from the basic SCSEP program. At the local project level, responsibility for the experimental projects generally rests with the SCSEP project director. However, some local projects have added a job developer to their staff to work on their experimental project. The staffing of experimental projects is discussed more fully in Section 3.2.4 below.

2.4 Participation of SCSEP Sponsors in Experimental Projects

Between January 1, 1983 and the present, 219 experimental projects were conducted.[1] Participation of SCSEP sponsors in the experimental program has varied. Table 2-1 lists the national and state sponsors of SCSEP programs that have participated in 502(e) experimental projects. The table displays for each sponsor the number of projects conducted in each year of the experimental program to the present.

A comment is in order about the figures contained in Table 2-1. Because some experimental projects are conducted at multiple sites, the figures contained in this table may slightly underrepresent the number of locations of experimental projects. For example, some national sponsors have conducted a "state-wide" experimental project with training located in five or six different locations. However, these "state-wide" projects which have operated in multiple locations are counted as one project in the table. Since the majority of projects have been conducted at one site, it is believed that the count of experimental projects shown in the table is close to the actual number of individual experimental project sites.

As shown in Table 2-1, all eight of the national sponsors of SCSEP (see Appendix B for a list of the national sponsors, their addresses, contact names and telephone numbers) and 11 states have at one time or another conducted experimental projects. Only three of the eight national sponsors of SCSEP have conducted experimental projects in every year since the beginning of the 502(e) program. One of these, the NCOA, has maintained a fairly stable number of experimental projects throughout the period. Another, NCSC, has escalated its program, more than tripling its experimental projects between PY 1984-85 and the current program year. The third, Green Thumb, has declined in participation from a high of eight experimental projects in PY 1983-84 to one project in the current program year.

Two national sponsors, ANPPM and the Forest Service, conducted experimental projects for one year only, the 1983-84 program year, and then dropped their experimental project effort. One national sponsor, AARP, began conducting experimental projects only in the current program year.

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[1] This figure is simply a total of the number of projects conducted during each program year. Because some projects are continued from one year to the next, these projects may be double-counted in the total number of projects shown. The unduplicated number of projects conducted is 132 (see Table 2-2).

Table 2-1

Participation of SCSEP Sponsors in 502(e) Experimental Projects January 1, 1983 - June 30, 1986

	Number of Projects			
National Sponsors	PY 83[1]	PY 83-84[2]	PY 84-85[3]	PY 85-86[4]
National Council on the Aging	11	12	10	13
Green Thumb	6	8	4	1
National Council of Senior Citizens	9	12	13	37
National Urban League	2	2	2	--
National Caucus and Center on Black Aged	--	5	8	7
Asociacion Nacional Pro Personas Mayores	--	4	--	--
Forest Service	--	5	7	--
American Association of Retired Persons	--	--	--	1
State Sponsors				
Alaska	1	1	1	1
Arkansas	--	2	--	--
Delaware	1	1	--	--
Indiana	--	--	--	1
Massachusetts	--	--	--	1
Missouri	--	1	--	--
New York	--	7	6	6
Oregon	1	1	1	1
Pennsylvania	1	1	1	--
Tennessee	--	1	--	--
Texas	1	1	--	--
Total All Sponsors	33	64	53	69

---

[1] PY 83 covers the period January 1 to June 30, 1983.
[2] PY 83-84 covers the period from July 1, 1983 to June 30, 1984.
[3] PY 84-85 covers the period from July 1, 1984 to June 30, 1985.
[4] PY 85-86 covers the period from July 1, 1985 to June 30, 1986.

Of the 11 states that have conducted experimental projects, only two, Alaska and Oregon, have conducted projects every year since the beginning of the 502(e) program. Pennsylvania conducted experimental projects from 1983 until the end of PY 1984-85, and discontinued its program in the current program year. New York has been involved in the experimental program for three years beginning in PY 1983-84. Two states conducted experimental projects only in the first year and one-half of the program and then dropped out. Three states dropped out after one year of participation and two became involved in conducting experimental projects for the first time in the current program year.

Although 11 states have participated in the experimental program at one time or another, only five states are participating in the current program year. The largest number of states conducting experimental projects occurred in PY 1983-84 when nine states were involved.

Table 2-2 contains figures on the number of new projects and the number of projects continued from prior program years for each year since PY 1983. About half of the experimental projects were dropped after one year during the study period, but in the current program year almost three-quarters of the experimental projects from prior years are being continued. Six projects have been continued since the first year of the experimental program, and another 12 projects are in their third year.

Table 2-2

Number of New and Continued Experimental Projects PY 1983 through PY 1985-86

	PY 1983	PY 1983-84	PY 1984-85	PY 1985-86
New Projects	33	48	20	31
Projects Continued from Prior Year	--	16	24	20
Projects Continued from Prior Two Years	--	--	9	12
Projects Continued from Prior Three Years	--	--	--	6
Total Projects	33	64	53	69
Percent of Projects from Prior Years Carried Over	--	48%	52%	72%

3.0 LOCAL EXPERIMENTAL PROJECT IMPLEMENTATION

This chapter discusses the implementation of 502(e) experimental projects at the local level. In Section 3.1, the objectives of the local experimental projects are examined. Section 3.2 discusses the design of the local projects and implementation procedures used. The training modalities used for the experimental projects are described in Section 3.3 and Section 3.4 addresses the participation of employers in the experimental projects.

3.1 Objectives of the Local Experimental Projects

A general consensus exists among 502(e) experimental project sponsors and local project operators that the primary objective of the experimental program is to place older workers in unsubsidized jobs in the private for-profit sector. However, different emphases are placed on targeting specific types of employment or industries (e.g., growth industries).

General agreement exists that the experimental projects should focus their efforts on placement in growth industries. However, it appears that the definition of growth industries varies. Some local projects appear to consider growth industries as employers which happen to be hiring at the time. Most local projects have placed less emphasis on placement in high technology fields. According to representatives of sponsors and local projects, the general feeling among local projects is that even entry level jobs in high technology fields require extensive training that they believe most unemployed older workers are reluctant to undergo.

The provision of work-sharing and flexitime as specified in the legislation for 502(e) is considered by local project operators to be the responsibility of the employers associated with the projects. The strategy used by the local project operators has been to concentrate on recruiting older workers that can meet the requirements and needs of employers.

One national sponsor views the objective of the experimental program as attempting to place low-skilled and minority older workers in jobs in the private sector which provide new skills training and employment opportunities. The experimental projects which have been conducted by this national sponsor target the private sector placement of low income, mostly minority, older workers.

Local operators of experimental projects list the following as their views of the objectives of the program:

- to find suitable private sector jobs for older workers,
- to show employers that older workers are reliable employees,
- to place older workers in growth industries,
- to combat age discrimination in the private sector,

- to make the public aware of the benefits of hiring older people.

One project operator considered the objective of his experimental project to be to have a significant enough success rate of placing older workers in the private sector that increased funding would be provided for the project.

3.2 Local Project Design and Implementation

This section discusses topics related to the design and implementation of the experimental projects. Five broad topics are addressed: Section 3.2.1 addresses strategies used by the experimental projects in designing programs to meet their objectives and describes the variations among sponsors in planning local experimental projects. The role of advisory committees in local project design and implementation is examined separately in Section 3.2.2. Staffing of the local experimental projects is discussed in Section 3.2.3. Finally, Section 3.2.4 addresses the recruitment of older worker participants for the local experimental projects.

3.2.1 Experimental Project Design

On November 2-3, 1983, a meeting of the operators of experimental projects -- the "Private Sector Experimental Meeting" -- was held in Washington, D.C. A quotation from the transcript of that meeting provides an insight into the strategies used by local projects in designing their experimental projects:

> The design of the program ... was based .. on the legislation. We had some problems with the direction from the legislation. The language tended to emphasize high tech, flexible work hours, etc. and there seemed to be the feeling from reading the legislation that the older workers had special needs which we should address. Our feeling was that we should treat them like everybody else and try to find them a job...whether it is high tech or low tech... We had some concern about the legislation trying to direct the program into some specific line of employment which was basically high tech... We felt the direction would be more appropriately aimed at "Let's get as many older people into jobs as we possibly can, jobs that suit them and are where they live." Formal analysis was not necessarily in order; we felt we knew the older workers and their needs already....I suspect that your exploitation of opportunities [in the private sector] are not going to come until after you get out on the street and start implementing the program. (p. 3)

Most local experimental projects are designed simply. Steps are taken first to determine the needs of employers in the project area and then to recruit older workers to fill that need. The needs of employers are typically identified in two fashions: 1) through a project advisory committee and 2) through direct contacts with employers in the private sector.

Planning for experimental projects typically has been conducted at the local level. The national sponsors have provided general guidance to their local projects and received proposals from affiliates interested in conducting experimental projects. The national sponsors' staff members have played active roles in designing and monitoring experimental approaches, but the details generally have been left to the discretion of local project operators.

Some experimental projects have conducted a formal market analysis or needs assessment to determine the types of skills needed in their service area. For example, one local project in a midwestern state mailed a questionnaire to 45 nursing homes in an eight-county area. The responses showed a need for trained nurses aides. An experimental project training program was set up to accommodate this need.

Some state sponsors have conducted planning activities similar to those described above. For example, one state sponsor undertook an extensive market analysis to locate high growth jobs for older persons, with some interesting results. The fastest growing industry in this southwestern state was construction, but it was found that opportunities were few for older workers in this industry. The computer industry had a demand for data entry persons. However, the market analysis revealed that the greatest opportunity appeared to exist in the supermarket industry which had a demand for workers to do price changes on Tuesday and Thursday mornings. This demand was incorporated into the experimental project's design and resulted in placements of older workers. Participants obtained positions as clerks, office workers, security personnel, and managers of specialty departments, such as flower and plant sales.

3.2.2 Use of Advisory Committees by Local Experimental Projects

At the local level, most project operators, following guidance from the sponsors, have tried to involve employers in the planning process. Many local experimental projects have created advisory committees or councils. Typically, these committees consist of representatives from local businesses and business organizations. In addition, the advisory committees often include representatives from related public agencies such as the JTPA program, the Department of Social Services and the vocational rehabilitation program.

The roles of the advisory committees vary. Most advisory committees have provided mailing lists of small businesses and have cooperated in the development of a brochure setting forth their endorsement of the experimental project. In some local projects, the advisory committees have assisted the staff of the local project in reviewing data presented by local or regional labor and economic development officials. The advisory committees also have helped to target firms that might employ older workers, and, in some cases, committee members have made the initial contact with employers on behalf of the local project.

Some advisory committees have played a more active role in the planning of the local experimental project by advising the project staff on the types of training to be used in the project. According to local project operators and sponsors, advisory committees encourage work experience and on-the-job training since these appear to be favored by many employers.

Beyond the initial program planning and development stage, that is, after about one year of experimental project operation, it was reported by project operators that the role of the advisory committee usually changed. In short, as an experimental project becomes more advanced the primary activity of the advisory committee tends to focus less on project design and more on public relations.

3.2.3 Staffing of Local Experimental Projects

Because of the requirement that experimental projects be conducted while maintaining the authorized level of SCSEP slots, funds for the administration of the experimental projects are scarce. Consequently, nearly all experimental projects are operated by existing SCSEP staff.

Typically, the experimental project is administered and operated by the SCSEP project director. In addition to his or her duties related to SCSEP project administration and operation, the experimental project director administers the experimental project, makes contact with the employers, and supervises recruitment and training under the experimental project. Assistance from other staff members may be provided. However, this assistance is in addition to the regular duties of these staff members and does not replace any other activities.

Some local projects have hired a part-time or full-time job developer for their experimental project. If the limited funds from the experimental projects did not cover this position, the sponsors sometimes approved temporary use of staff working for the SCSEP project. In many projects, the job developers have had considerable involvement with participants as well as with employers.

Overall, it is estimated that the administration and operation of an experimental project at the local level takes about one person-year of effort. One project operator estimated that it takes the full-time equivalent of one staff person for every 20 placements. Most operators reported that the most intensive level of activity occurred during the first year as initial contact was made with the private sector. The effort was reported to be less in subsequent years, but only a limited number of projects operated beyond the second year. In general, project operators reported that the experimental projects were labor- intensive and time-consuming activities.

3.2.4 Recruitment of Older Worker Participants in the Experimental Projects

In spite of the differences in purpose between the two programs, the procedures used to identify, serve, and place 502(e) enrollees are similar to those used for SCSEP enrollees. However, most local project operators have found that recruitment outside of the SCSEP program (i.e., of non-enrollees) is desirable in order to find applicants who are willing to attempt private sector employment, are motivated to seek full-time employment, and who possess work skills and other characteristics which match the expectations of the employers.

Local project operators are acutely aware that the success of the first placements in the private sector can affect the future success of an experimental project. Consequently, most of the local projects have concentrated their recruitment efforts away from SCSEP enrollees. Many project operators believe that SCSEP enrollees require more training and assistance to prepare for private sector employment than they can provide in their 502(e) experimental projects. In addition, local project operators are not certain about how well many SCSEP enrollees would perform in a private sector job.

Only one sponsor, a national sponsor, recruits all experimental project participants from its basic SCSEP enrollees. SCSEP enrollees are assessed by project staff to identify those expected to be most successful in making the transition to the private sector. Enrollees are encouraged to attempt this transition by the promise that they will be able to return to the basic SCSEP program if they are not satisfied with the results of their affiliation with the experimental project.

Typically, the local projects recruit experimental project participants almost entirely from outside the SCSEP program. New recruits are generally not encouraged to consider enrollment in SCSEP. This policy is believed to give the participant a feeling of urgency and importance about securing unsubsidized placement in the private sector. Nonetheless, if the non-SCSEP participant in an experimental project is unable to succeed in the private sector, most projects admitted the participants in their basic SCSEP program after all.

Some local experimental projects located in areas with high unemployment reported that they had a pool of relatively well-educated, adaptive and skilled older job seekers due to plant closings in the area. In a small number of cases, local project operators reported that drawing experimental project participants from this pool facilitated recruitment and placement because of the availability of older persons with good work experience who could be easily trained. However, this pool rapidly diminished and once again placements became more difficult as recruits for the experimental projects tended to have less work experience.

Once an enrollee is placed, project operators make frequent on-site monitoring visits to assure that the training needs are being met by the employer and that the enrollee receives the proper supervision and instructions. The project director or the job developer generally is responsible for conducting these monitoring activities. Given the short duration, usually less than six weeks, of most work experience and on-the-job training, the monitoring occurs approximately every two or three weeks.

3.3 Types of Training Used by the Local Experimental Projects

The experimental projects use four basic types of training: classroom, work experience, on-the-job training, and transitional services. Classroom training has been the most popular form of training, especially during the initial years of the experimental projects. Classroom training provides several weeks of occupational skills training in such areas as word processing and health care. The work experience mode of training places the participant with a private sector employer with wages paid by the experimental project, much as SCSEP enrollees are placed in the public sector. Increasingly popular is on-the-job training in which the participant is actually hired by the employer. Nearly all projects provide some form of transitional services, such as job readiness training, for experimental project participants.

Most sponsors have offered more than one training mode in their experimental projects, although in one year three sponsors focused their experimental projects on one form of training (on-the-job training). In general, participants in experimental projects also receive more than one type of training. However, information is not available to determine exactly how many individuals receive multiple training modes, or what combinations of training modes are provided to participants. The four basic types of training employed are described in more detail below.

3.3.1 Classroom Training

In a letter to sponsors in September, 1983, the Division of Older Worker Programs defined two types of classroom training for experimental project reporting purposes:

> Classroom Training (Occupational Skills) refers to a classroom situation such as a typing class where a specific occupation is taught. Classroom Training (Other) refers to other types of training such as basic education, GED preparation or other activities of a more general nature.

Many experimental projects have used classroom training to develop specific skills in older workers. Available data indicates that a greater proportion of participants received classroom training than any other form of training. In PY 1983-84, over 400 enrollees, or about 40% of the participants in experimental projects, received classroom training. The available QPRs indicate that at least five sponsors offered classroom training that year. In PY 1984-85, available data indicates that slightly under 400 enrollees took classroom training. At least four sponsors offered classroom training in their experimental projects in that program year.

Local projects have used classroom training programs ranging from three weeks to one year in length. For example, an experimental project in a large urban area has found that a three-week brush-up course is successful in updating the skills of older workers interested in clerical work.

One national sponsor has used classroom training in an intergenerational setting in several states. Local Job Corps Center classroom training is used. Classroom training is provided for such occupations as nursing assistant, waste water treatment plant operator, warehouse worker, teacher's aide, groundskeeper, building maintenance worker, and cook/chef. The training approach sets standards for achievement based on performance standards used in the occupation. Detailed educational records are maintained for trainees and each individual is assessed by training center staff on how well he or she is doing in a variety of skill areas. Many older workers in this program also receive on-the-job training from their private sector employer after they have completed this training program.

Age integrated classroom training also is used in a state-sponsored project in the West to provide older workers with skills in word processing. In this project, the local project operator felt that since the work place is age integrated, the classroom should be as well. The instructional staff was initially concerned about mixing older students with the younger students, all of whom were under the age of 30. However, by the third week of the 240 hour curriculum, considerable rapport existed between the younger and the older students. All the older students graduated with honors.

3.3.2 Work Experience

Work experience also is used commonly in the experimental projects. DOL defined work experience in Older Worker Bulletin 82-15 as:

> training at a defined, supervised private sector worksite [that is to] result in the acquisition or development of work skills and knowledge, exposure to new occupations, and to demonstrate the skills and capabilities of the older worker to a prospective employer.

Work experience is reported to be used most frequently in high growth or high technology industries in order to give the older worker some experience in the field before being placed with an employer. In some cases, work experience is considered a trial employment period after which the employer hires the worker if he or she proves satisfactory. The technique is intended to make the applicant more attractive to employers by demonstrating the ability of the worker to do the job and by providing the worker with actual job experience.

One sponsor set up work experience programs in three midwestern states. In these programs, applicants were matched with employers by older worker specialists. All three projects asked employers to sign a non-binding hiring agreement which stated the employer's intent to hire if performance was satisfactory. The work experience was for 160 hours, but at mid-point, after 80 hours, the employers were asked to evaluate the trainees. At this point, trainees were transferred if there appeared to be little chance that they would be hired. For other trainees, mid-course corrections that seemed indicated in the training program were made. The project operators all agreed that the mid-point evaluation was a valuable tool.

One sponsor has successfully combined 80 hours of classroom training with 80 hours of supervised work experience in an experimental project in the West. The classes were held in a local community college and were age-segregated. The curriculum was designed by a certified home health agency based on a course approved by the U.S. Department of Health and Human Services. This approval makes it possible to obtain medicare reimbursement for services performed by the home health aides completing the course. The home health agency conducted the classroom training, selected the work experience settings and provided some on-site supervision.

The same sponsor also has combined 80 hours of classroom training with 80 hours of clinical training and 80 hours of work experience to train nursing home aides in a Southern state. The training was conducted by health care consultants who operate a nursing home. During a six week course, older persons were taught basic nursing skills. A variety of instructors presented information on such topics as routine patient care, and emergency first aide procedures. The classroom experience was followed by 80 hours of clinical training which stressed learning-by-doing activities. The participants then were matched with available openings with health service agencies and health care facilities. The employers interviewed two or three trainees for each opening. Each employer then selected a single trainee who received 80 hours of field placement. This allowed the trainee to prove his or her abilities to the prospective employer while under the auspices of the program. The project operators found the field placement to be beneficial since the work experience allowed the employer to fully evaluate the employee's performance prior to making a final hiring decision.

3.3.3 On-The-Job Training

In Bulletin OW 82-15, DOL defines on-the-job training as:

> training in the private sector given to an individual who has been hired first by the employer, while he or she is engaged in productive work which results in the individual's acquisition of new skills or knowledge.

On-the-job training has increased in proportion to other training modes since the start of the experimental projects. Project operators reported that many employers originally resisted OJT because they feared the red tape of governmental programs and felt that they might be obligated to retain the older worker regardless of performance. As project operators were able to show businesses that OJT was relatively free of paper work and that the older worker would be hired permanently only after a trial period, more employers accepted the concept.

One national sponsor used on-the-job training exclusively during the program years in which it conducted experimental projects. Other sponsors have offered OJT along with other training modes, such as classroom training and work experience. Five sponsors reported using OJT in PY 1983 although information on the number of participants trained in this mode during that year is not available. According to available records, six sponsors offered OJT in PY 1983-84 to at least 112 participants. In PY 1984-85 four sponsors offered OJT to at least 82 participants. Overall, the number of participants in OJT, according to available QPRs, accounted for about 10 percent of participation in any type of training.

The OJT approach implemented by one national sponsor was designed to facilitate monitoring by the local project. The experimental project operators were to seek employers willing to hire one or two enrollees and orient them to their jobs. The employer simply had to hire the enrollee for a trial period, keep track of the enrollee's time and sign the enrollee's time sheet. Staff associated with the project operator visited the enrollee on the job every two weeks. Under this program, the experimental project paid the enrollee's wages and fringes for a maximum of 260 hours of work. The employer agreed in advance to hire the worker if performance is satisfactory. If the employee did not perform satisfactorily, the local project expected the employer to terminate the enrollee before the end of the six week trial period. Any employer who retained an enrollee for the maximum number of hours and then did not hire the enrollee was not to be assigned any additional enrollees. On the other hand, successful placement automatically qualified an employer for one or two more enrollees.

In another OJT approach developed and currently used by a local project, the project operator and the employer work together to design a job that can be filled by an older worker. The project then recruits an older worker who can most likely do the work. The employer provides on-the-job training to the older worker. The project pays the wages of the older worker and monitors the training. The project also pays the employer to do the training. The employer is, in effect, a subcontractor to the project for purposes of training the enrollee. Since the training is to the specifications of the employer, this approach is referred to by the project as "employer based training." After an agreed-upon trial period, the older worker is offered the job on a permanent basis, if he or she has proven satisfactory.

3.3.4 Transition Services

In its September, 1983, letter to sponsors, the Division of Older Worker Programs defined transition services to include:

> such activities as job clubs, job fairs, job referral and/or counseling but only when it is the only activity provided to the participant...[transition services may also] include such activities as supportive services, health referrals and similar activities.

Most sponsors of experimental projects have reported providing transition services in their projects. Experimental projects have offered such activities as orientation sessions and job readiness programs, and referrals to special classes, such as English as a second language.

A common transition service provided by experimental projects has been the conduct of job clubs to assist older job seekers. These clubs combined classroom lectures with group support activities. The lectures covered such topics as preparation of a brief "commercial" that the enrollee could use to sell himself or herself to an employer, methods for making telephone contact with potential employers, and approaches for making a good impression during interviews.

In an experimental project in a rural area, job banks have been used to gain entry to the private sector. The job bank consists of applicants who are slightly above eligibility for SCSEP and are trained under the experimental project. The enrollees are given OJT in private sector jobs with employers who have signed agreements to hire the enrollees after training.

Transition services appear to be provided to a large proportion of experimental project participants. The limited information available indicates that transition services are provided to almost half of the participants in experimental projects. However, for a number of these, it appears that the strict definition of transition services does not apply since these services do not appear to be the only services provided.

3.4 Employer Participants

The most significant challenge faced by the local operators of experimental projects has been to obtain the involvement of private sector employers. Two primary barriers have had to be overcome. First, the experimental project operators have found it necessary to convince employers that older workers were a good investment, since age discrimination was encountered among the employers contacted. Second, project operators also had to overcome employer hesitancy to become involved in a program which might require a lot of paperwork and red tape.

In order to convince employers of the value of older workers, many experimental projects relied on existing contacts with the private sector or set up advisory committees to assist in getting information to businesses concerning the dependability and performance of older workers.

Employer concerns about paperwork and red tape often were addressed through group meetings with potential employers or through individual contacts. In most cases, the employers were convinced that the paperwork was minimal. Some local projects provided employers with fact sheets and simplified forms to help overcome these barriers. Project operators found that employer involvement in experimental projects was facilitated by simplifying the bureaucratic procedures for participation and making exceptions to existing procedures, as required.

As techniques were developed to combat the initial barriers to involving private sector employers in the experimental projects, local project operators found that securing placement of experimental project participants still was a difficult process. Project operators frequently were turned down by employers and the amount of time required for employer contacts was discouraging.

Local project operators reported their greatest success in involving small and mid-sized businesses in their experimental projects. These were also the companies more likely to hire the older workers placed by the local experimental projects. According to the local project operators, these relatively small businesses reacted positively to the simplicity of the experimental projects.

Most project operators reported that larger companies have been more difficult to involve in experimental projects because they had multiple policy and decision points and were more bureaucratic in nature. However, at least one experimental project was successful in involving a large chain in its program and others have found that some fast food chains are interested in hiring older workers although they are unwilling to provide training.

Many projects relied on a job developer to make contact with potential employers. The job developer, for example, would talk to the potential employer about the needs of the company and then negotiate a contract that satisfied both the employer and the project.

It appears that personal contacts are important to solicit the involvement of private sector employers in the experimental projects. Several local projects attempted to market employers through a mass mailing, but the results of these efforts were discouraging. For example, one national sponsor sent an inquiry letter to all the Fortune 500 companies asking if they were interested in hiring talented older workers. Fewer than 100 responded and nothing came of these contacts.

Employer participation in the local experimental projects was reported in a variety of fields: home health care, clerical, assembly, construction, custodial, retail, and hotel/motel management. However, local project operators reported that most jobs in high technology companies were unlikely opportunities for their experimental projects. Many of these jobs require skills in engineering. Other jobs, such as routine assembly, are increasingly performed by robots. However, one local experimental project placed an older worker in a job with a small company checking the work of robots.

4.0 COORDINATION LINKAGES ESTABLISHED

Because their objective is to promote placement in the private for-profit sector, the 502(e) experimental projects placed emphasis on the establishment of linkages with the private sector. In addition, as a result of their experimental projects, some local projects developed linkages with JTPA programs. This chapter addresses the coordination linkages established by the local experimental projects.

4.1 Private Sector Linkages

The DOL has required experimental project sponsors to coordinate with the private sector in the development and implementation of experimental projects (see Older Worker Bulletin 83-7, for example). Consequently, all of the experimental projects have established some linkages with the private sector. As one project operator put it, the project operators learned to "take baby steps" for entry into the private sector.

The first step for many project operators was to set up an advisory committee consisting of local businesses, educators and employment specialists. These committees met to identify placement opportunities and review training approaches, but one of their most important roles was to provide a link between the experimental project and the private sector. In this capacity, the advisory committee assisted project staff in making plans to implement the project and then facilitated communication with the employer community. Advisory committee members helped identify potential employers and either made direct contact with employers on behalf of the project or endorsed the contacts made by the project staff. Some advisory committee members had conducted previous training under CETA and were able to contact employers through networks developed in the past.

Several local projects held round-table discussions and meetings to explain the public-private partnership. These meetings were used to inform business representatives about the purpose of the experimental projects. The most effective method, as reported by the project operators, was to have a business person speak who hires older workers and profits from their employment. Testimonials from business representatives to business representatives were reported to be the key to successful round-table discussions and meetings.

Most project operators found that it was very important to cultivate information sources among public and private sources. For example, one local project called a meeting of local economic development officers who provided information on growth opportunities in the area. These officials are responsible for attracting new business to an area and often have advanced information on the types of employers and jobs that will be opening up in the near future. Maintaining contact with these officials paid off for several projects. For example, project staff in a midwestern city learned from a local development official that a private outdoor recreation center was opening up. The project contacted the center's owner and several older workers were hired to operate the concessions.

Another important linkage was with local employment services. From these sources, the project operators were able to get information on trends in hiring and were able to compare their placement rate with fluctuations in the local labor market. For example, in many labor market areas the placement rate remained high in spite of seasonal downturns in the employment rate. This was used by project operators to demonstrate that the experimental projects could work effectively even against local downturns in hiring.

Some local projects served as employment agencies. For example, a few sponsors enlisted the support of employers to pay for older worker recruitment ads. In return the experimental project screened applicants for placement with the employer.

Local project operators reported that they encountered many barriers such as age discrimination and reluctance to hire non-English speaking older persons. However, project operators learned how to network with the private sector and take maximum advantage of their connections. For example, operators in a state with many non-English speaking migrants used contacts with the hotel industry to place older workers.

4.2 Linkages With JTPA and Other Programs

A variety of mechanisms can be used by local experimental projects in establishing linkages with JTPA programs. For example, experimental project participants can take JTPA training, with fees paid either by the JTPA project or by the experimental project. Experimental project participants can participate in work experience or on-the-job training and also be trained under JTPA. Project operators for the two programs can share information on jobs and training programs, and experimental project operators can apply to be the subgrantee for JTPA training funds.

Linkages with other employment and training programs have been informally encouraged by the DOL since the inception of the experimental projects. In 1986, the sponsors were formally requested to coordinate with other training programs. As stated in Bulletin OW 86-9:

> Sponsors of experimental projects are encouraged to seek training assistance from all available resources and particularly from programs operated under the Job Training Partnership Act. Dual enrollment in experimental training and JTPA activities may be in the best interests of a number of participants. Eligibility for JTPA, of course, is determined by the operators of the JTPA program.

In general, JTPA eligibility requirements are at the poverty level. Since SCSEP enrollees may have income up to 125 percent of poverty, and experimental project participants may have income up to the BLS budget level, not all enrollees are eligible for JTPA programs. Further, the mechanisms for the distribution of JTPA funds among programs for older workers are established independently by each state. Finally, there is considerable variation in the amount of money available for older workers in accord with the variations in each state's overall JTPA funding.

In most local areas where experimental projects have been conducted, JTPA programs were just getting started as the initial 502(e) projects were being implemented. It appears that the majority of experimental projects conducted during the study period had little contact with JTPA. In the words of one project operator: "the project was small and self-contained and did not require coordination outside the sponsor agency."

Nonetheless, some linkages have been established between the two programs. Several experimental project operators reported that they had worked closely with JTPA staff to coordinate training and referral services and share information. One local project operator reported that the Private Industry Council had a great demand for older workers. The PIC was "so happy to have some older persons [to place that they picked] up all of the costs on work experience".

In a northern state-sponsored experimental project, all of the experimental project enrollees were enrolled in JTPA training as security guards, upholsterers and receptionists. Several other projects linked with JTPA by sending enrollees to participate in job readiness and job club programs operated by JTPA. The mechanisms for linkage varied, but most JTPA operators charged no fees for the experimental project participants. In a rural area, the experimental project linked with JTPA and provided transportation for enrollees to the county seat to attend JTPA training.

Some experimental projects also operated JTPA programs. For example, in a southwestern state, one experimental project credited its operation of the 502(e) project with helping it secure and operate a project under the JTPA 3% set-aside program. In an area with high employment rates, the experimental project linked with JTPA to recruit and train applicants in clerical occupations under the 3% set aside and Title IIB. The JTPA program does the recruitment and training, while the experimental project covers the costs.

Aside from one sponsor who used Job Corps Centers as training sites for older workers, few linkages with other employment programs were established by the experimental projects. In many cases, the other employment programs, such as vocational education, referred older persons, usually the more difficult to place, to the 502(e) projects. A few experimental projects made arrangements with community colleges and technical or vocational education schools to provide classroom training for enrollees. An occasional linkage was established with vocational rehabilitation programs to provide specialized services to enrollees with handicaps.

5.0 CHARACTERISTICS OF PARTICIPANTS IN EXPERIMENTAL PROJECTS

This chapter discusses the characteristics of participants in the 502(e) experimental projects. All data presented in this chapter are estimates based upon the most complete information available. As discussed in Chapter 1.0 of this report, data are not uniformly available for all of the 502(e) experimental projects conducted during the study period. Consequently, even the total number of participants in experimental projects is not known with certainty. However, the estimates given in this chapter are believed to provide a reasonable approximation of the overall 502(e) participant population.

The remainder of this chapter contains two major sections. The first section which follows discusses the number of participants in experimental projects during the study period. Also included is a discussion of the age and sex of experimental project participants, their income, ethnicity, and education. The second section which follows provides a comparison of the characteristics of experimental project participants with the characteristics of participants in the basic SCSEP program.

5.1 Characteristics of Experimental Project Participants

Table 5-1 presents the best data available on the number of persons that participated (i.e., enrolled) in experimental projects for each program year in the study period. As shown, the total number of participants in experimental projects was about 650 in the first program year. The number of participants peaked in the second program year at about 1,150, and declined slightly in the third program year to abouth 980. In contrast, the basic SCSEP program for 1984-85 had 31,664 participants (new enrollees). The number of experimental project participants nationwide is thus only about three percent of the size of the SCSEP new enrollee population.

Table 5-2 provides information on the characteristics of experimental project participants for each year in the study period. The table contains the percentages of participants falling into various categories by sex, age, race, and education.

The majority of experimental project participants are female. The predominant ethnic group of experimental project participants is white, with minorities accounting for between about one-quarter and about 40 percent of the participant population. Participants in experimental projects are generally relatively young and well-educated. Only about one-fifth of the experimental project participants are age 65 or more, and almost two-thirds have a high school education or better.

5.2 Comparison of Experimental Project Participants and SCSEP Enrollees

Available information indicates that fewer than 15 percent of experimental project participants are recruited from among the ranks of SCSEP enrollees. A comparison of the characteristics of experimental project participants and SCSEP new enrollees (see Table 5-3) is

Table 5-1

Estimated Number of Participants in Experimental Projects

	Participants for Which QPR Data are Available	Estimated Total Participants
PY 1983	654[1]	654
PY 1983-84	1,106[2]	1,150[3]
PY 1984-85	914[4]	980[5]

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[1] Based on QPRs from three national sponsors and two states, plus data contained in "Department of Labor Report on Experimental Activities in Compliance with the Requirement of Section 502(e)(3) of the Older Americans Act," December, 1984.

[2] Based on QPRs from all seven national sponsors and eight of nine state sponsors of experimental projects.

[3] Based on the assumption that the state sponsor for which QPR data are missing had a number of participants equal to the average of participants in the other eight states.

[4] Based on QPRs from all six national sponsors and three of four state sponsors of experimental projects.

[5] Based on the assumption that the state sponsor for which QPR data are missing had a number of participants equal to the average of participants in the three state sponsor programs for which data are available.

Table 5-2

Characteristics of Experimental Project Participants (Percentages)

	PY 1983[1] (%)	PY 1983-84[2] (%)	PY 1984-85[3] (%)
Sex			
Male	21	30	27
Female	79	70	73
Age			
55-59	48	47	43
60-64	32	30	34
65-69	15	16	14
70-74	5	4	7
75+	<1	2	2
Ethnic Group			
White	58	79	68
Black	35	15	26
American Indian	1	1	1
Other (including Hispanic)	6	5	6
Education (years)			
0-8	15	17	14
9-11	24	20	20
12+	61	64	66

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[1] Data extracted from Final Quarterly Progress Reports for three national sponsors and one state that conducted 502(e) experimental projects during the program year.

[2] Data extracted from Final Quarterly Progress Reports for seven national sponsors and five states that conducted 502(e) experimental projects during the program year.

[3] Data extracted from Final Quarterly Progress Reports for six national sponsors and two states that conducted 502(e) experimental projects during the program year.

Table 5-3

Characteristics of Experimental Project Participants and New Enrollees in SCSEP PY 1983-84

	Experimental Project Participants (%)	New SCSEP Enrollees (%)
Sex		
Male	30	38
Female	70	62
Age		
55-59	47	43
60-64	30	29
65-69	16	16
70-74	4	8
75+	2	4
Ethnic Group		
White	79	63
Black	15	24
American Indian	1	2
Other	5	11
Education (years)		
0-8	17	24
9-11	20	21
12+	64	55

Sources: See Table 5-2 for Experimental Project Participants. Data on SCSEP enrollees from DOL, Quarterly Progress Reports, National Summary of All Sponsors.

consistent with the observation that the two populations are recruited separately.

As shown in Table 5-3, experimental project participants generally are more likely than SCSEP participants to be female, more likely to be white, more likely to be under the age of 60, and more likely to have 12 or more years of education. This may reflect, in part, differences among applicants in their motivation for private sector employment. For example, project operators reported that many ideal candidates for the experimental projects were women between 55 and 60 years of age who recently had been widowed or divorced, and who were not yet eligible for Social Security. Women in this situation were oriented to full-time rather than part-time employment, had no objection to employment in the private sector, and welcomed the assistance available through experimental projects.

The differences between the characteristics of experimental and "regular" SCSEP participants also may reflect "creaming" of available applicants in response to the hiring preferences of private sector employers. For example, the higher educational level of the experimental participants may arise, in part, from employer insistence upon a high school diploma as a basic employability criterion. Of greater concern is the difference between the two programs in their levels of minority participation. All three minority-based national sponsors conducted experimental projects during PY 1983-84. However, the number of participants in these projects was small relative to the total experimental project enrollee population.

6.0 PARTICIPANT OUTCOMES

This chapter discusses the placement of experimental project participants in unsubsidized jobs in the private sector. Section 6.1 discusses the placement rates of experimental projects and examines placement rates by the characteristics of participants in the experimental projects. Section 6.2 describes the types of occupations that experimental project enrollees entered. Section 6.3 provides a discussion of wages paid to experimental project participants upon placement. Section 6.4 provides a rough estimate of the costs per placement of the experimental projects.

Very limited data are available on wages and costs per placement for the experimental projects. This chapter provides estimates of these figures based on data from only three national sponsors. Hence, the information provided on wages and costs is not necessarily representative of the universe of experimental projects.

6.1 Experimental Project Placement Rates

Table 6-1 provides estimates of the placement rates of the experimental projects during each year of the study period. As indicated in the footnote to the table, information on the number of enrollees in the experimental projects and on the number of placements was not available for all sponsors of these projects in all years. However, based on the figures shown in Table 5-1, the available information on placements represents about 96 percent of the experimental project population. Thus, the estimates are believed to be very close to the full experimental project placement rate.

Placement rates have been slightly over 50 percent in each year the experimental projects have been conducted. Placement rates for the individual sponsors ranged widely, from 17 to 80 percent in PY 1983, from 20 to 93 percent in PY 1983-84, and from 0 to 80 percent in PY 1984-85.

Extremely limited data are available on the characteristics of enrollees placed under the experimental projects. Data are available only from three national sponsors on the age and education of enrollees placed. According to these sources, about 79 percent of all experimental project placements are accounted for by enrollees under the age of 65. This results is consistent with Table 5-2 which showed that between 77 and 80 percent of experimental project participants are under the age of 65.

The educational level of experimental project placements, according to the three national sponsors for which data are available, is about half above and half below the high school level. Although Table 5-2 indicated that almost two-thirds of the experimental project participants have at least a high school education, the limited data on placements is insufficient to draw any conclusions about the relationship between educational level and placements in the experimental projects.

Table 6-1

Estimated Placement Rates of Experimental Projects

	PY 1983[1]	PY 1983-84[2]	PY 1984-85[3]
Number of Starts (New Enrollees)	654	1,106	914
Number Placed	339	627	496
Placement Rate[4]	52%	57%	54%

---

[1] Based on QPRs from three national sponsors and two states, plus data contained in "Department of Labor Report on Experimental Activities in Compliance with the Requirement of Section 502(e)(3) of the Older Americans Act," December, 1984.

[2] Based on QPRs from all seven national sponsors and eight of nine state sponsors of experimental projects.

[3] Based on QPRs from all six national sponsors and three of four state sponsors of experimental projects.

[4] Calculated by dividing the number of placements by the number of enrollees that entered the experimental project during the period.

Note: Because information on number of starts and placements is not available for all sponsors, the placement rates shown here are estimates based on the best available data.

6.2 Occupations of Experimental Project Placements

Experimental project participants have been placed in diverse occupations and industries. Table 6-2 illustrates the breakdowns of the occupational fields of experimental project participants for each year in the study period.

As shown in this table, occupations in the health, clerical, and services fields predominate in experimental project placements. Occupations in the health field include health care aides, nurses' assistants, and hospital aides. Clerical occupations and occupations in service industries comprise another substantial proportion of the experimental project placements. Typists, receptionists, word processors, and food service workers and day care attendants are common in these fields.

Following is a sample listing of some of the occupations in which experimental project participants have been placed:

- health care aides
- clerical workers
- customer service representatives
- real estate sales persons
- banking clerks
- retail managers
- dental assistants
- printing clerks
- marketing representatives
- security guards
- grounds maintenance personnel
- museum workers
- amusement park attendants
- private school aides
- day care aides
- for-profit hospital aides
- word processors
- restaurant workers
- map cartographers

6.3 Wages Earned

Very limited wage rate data is available for experimental project placements. Data are available on wages from only three national sponsors that conducted experimental projects. Basically, these sources indicate that just under two-thirds of the experimental project placements are paid the minimum wage of $3.35 per hour. About one-fourth receive $4.00 per hour or more.

Also according to the limited data available, experimental project participants who received on-the-job training were more likely to receive the minimum wage than higher wages. Participants who had received work experience or classroom training under the experimental project were more likely to receive higher wages when they were placed. Experimental project participants who entered full-time jobs received higher hourly wages than those who entered part-time jobs.

Table 6-2

Occupational Fields of Experimental Project Placements

Occupational Field	PY 1983[1] (Percent)	PY 1983-84[2] (Percent)	PY 1984-85[3] (Percent)
Health	57	21	33
Clerical	15	29	18
Services	14	19	15
Retail	N.A.	5	5
Manufacturing	N.A.	10	7
Other	14	16	21

---

[1] Taken from "Department of Labor Report on Experimental Activities in Compliance with the Requirement of Section 502(e)(3) of the Older Americans Act," December, 1984. Data in this report were based on a sample of experimental projects.

[2] Based on QPR data from six national and five state sponsors.

[3] Based on QPR data from six national sponsors and three state sponsors.

6.5 Estimated Costs Per Placement

Data on the actual costs of the experimental project were not available for all sponsors in all years in the study period. However, based on available, data, experimental project costs per start and per placement can be estimated.

Table 6-3 presents estimates of actual costs per start and per placement of the experimental projects by year, based on available data. This table indicates that, while experimental project costs per participant were relatively stable in the two program years of the experimental projects, these costs declined substantially in the third program year. Project ccosts per participant were $887 in the first program year, $986 in the second program year, and $616 in the third year. Project costs per placement were about $1,600 PY 1983 and PY 1983-83. Costs per placement fell about 30 percent to approximately $1,100 in PY 1984-85. Project costs per participant and per placement have declined as sponsors have gained more experience in conducting experimental projects.

These estimates of costs per start and costs per placement are based on the combined costs of all participants trained under the experimental projects for the particular sponsors. One sponsor, however, provided information on the actual costs of training by occupation of experimental project participant. For this sponsor, costs per placement ranged from $500 to $5,500. These costs varied considerably depending on the occupation in which the training was provided. For example, classroom training for word processors was relatively expensive, whereas classroom training for nursing aides was less expensive.

Table 6-3

Actual Cost Per Start and Cost Per Placement

	PY 1983[1]	PY 1983-84[2]	PY 1984-85[3]
Cost Per Start	$ 887	$ 986	$ 616
Cost Per Placement	$1,026	$1,640	$ 1,137

---

[1] Based on data from four national sponsors and four state sponsors.

[2] Based on data from six national sponsors and six state sponsors.

[3] Based on data from five national sponsors and two state sponsors.

7.0 EXPERIMENTAL PROJECT WEAKNESSES AND ACCOMPLISHMENTS

This chapter begins with a description of the factors which may have inhibited the success of the experimental projects (Section 7.1). Next, the significant accomplishments of the experimental projects are discussed, with particular emphasis on the impacts of the projects on SCSEP (Section 7.2).

7.1 Factors Inhibiting the Success of the Experimental Projects

Four major factors may have inhibited the success of the experimental projects. Some of these may also have discouraged some local projects from initiating experimental projects. Specifically, these factors are:

- The low level of funding available for the projects;
- The significant administrative burden imposed on local operators by the experimental projects;
- The limited dissemination of information on experimental projects among project operators; and
- The lack of recognition for successful implementation of experimental projects.

Each of these factors is discussed in the paragraphs which follow.

Funding of the experimental projects was very limited. Local project operators were allowed to divert funding from their SCSEP operations to conduct experimental projects, yet at the same time they were required to maintain their authorized SCSEP slot level. The lack of additional funding for the experimental projects made it difficult for local projects to allocate staff to experimental project operations. State sponsors in particular would have felt the financial constraints, since their SCSEP funding levels were smaller than those of the national sponsors. Limited funding for the experimental projects may account for the lack of state participation in the 502(e) program -- only 10 states have conducted experimental projects.

Experimental projects placed a significant burden on the administrative staff of the SCSEP projects. It is estimated that administration and operation of an experimental project at the local level takes at least one person-year of effort per year. SCSEP projects have a median staff size of 2.5 persons. The administrative burden imposed on a staff of this size by an experimental project was regarded, in many instances, as intolerable.

The dissemination of information among experimental project operators has been slow and uncertain. Experimental project operators held a meeting in November, 1983 to exchange information on approaches to older worker placement in the private sector. However, this meeting occurred early in the life of the 502(e) program, and no other comparable meetings have been held since. Some national sponsors have held meetings of experimental project operators under their sponsorship, but no crosponsor meetings of experimental project operators have taken place.

A widespread concern of experimental project operators is that they perceive a lack of recognition for successful implementation of experimental projects. While the inherent benefits of experimental projects generally are recognized by local project operators, they are discouraged by a perceived lack of recognition from the DOL and from the sponsoring organizations for their efforts and accomplishments.

Placements under the experimental projects do not count toward meeting placement goals under SCSEP. As a result, some projects appear to have used a "dual enrollment" technique to increase their SCSEP placement rates. Experimental project participants were recruited for participation in the experimental project but were first enrolled under SCSEP and then transferred to the experimental project. Thus, when a participant was placed in an unsubsidized job under the experimental project, the placement also would count under SCSEP. It is not clear how widespread this practice has been. However, as stated in Chapter 5, it is estimated that less than 20 percent of the experimental project participants have been recruited from "regular" SCSEP enrollees.

7.2 Significant Accomplishments of the Experimental Projects

The significant accomplishments of the experimental projects fall into four broad categories:

- The experimental projects opened up private sector opportunities for placement of older workers, including SCSEP ineligibles and SCSEP enrollees;
- The experimental projects increased the visibility of the SCSEP projects in the community;
- The experimental projects expanded the services of local projects to a broader population of older workers; and
- The experimental projects gave project staff expanded experience in the various training approaches appropriate for older workers.

Each of these accomplishments is discussed in the paragraphs which follow.

Experimental project operators have found that the most significant accomplishment of their experience with experimental projects has been the increased knowledge project staff gained in placing older workers in occupations in the private sector. Further, the experience gained in private sector placement was found to be relevant to the SCSEP emphasis upon transitioning enrollees to unsubsidized employment. Although one experimental project operator reported that making placements under the experimental projects has been difficult, "like pulling teeth," experimental project operators reported that their experience in conducting experimental projects stimulated greater project emphasis on private sector placement of SCSEP enrollees. In addition, the advisory committees and other private sector contacts developed as a result of the experimental projects were found by some experimental project operators to be helpful in placing SCSEP enrollees.

Experience with the experimental projects gave the SCSEP program staff an opportunity to expand their knowledge of the private sector. SCSEP staff who contributed to experimental projects, for example, gained experience in conducting market analyses and in recruiting older workers likely to succeed in the private sector. The project operators also gained experience in responding to objections raised by private sector employers concerned about hiring older workers.

Some local project operators directly incorporated features of their experimental projects in their SCSEP program. One project, for example, had included a job search workshop as the initial service provided to all participants in its experimental project. Although the experimental project was not continued, as a result of this experience, all SCSEP enrollees now must attend a three-week job search workshop when they first enroll with the project. Only those who complete this workshop and are unsuccessful in finding unsubsidized employment are then assigned to a position with a host agency.

Many experimental project operators found that their experience with the projects increased their ability to identify skills or credentials required by older workers to improve their opportunities in the private sector. Some project operators became aware of certification requirements and other procedures associated with certain occupations for the first time as a result of their involvement in experimental projects.

Experimental project operators also reported that the exposure the projects gained in the private sector had a positive impact on their SCSEP operations. It was believed by some project operators that the local climate for hiring older workers (both SCSEP and experimental project enrollees) had been improved by their efforts in conducting experimental projects.

Many experimental project operators viewed the experimental projects as a complement to their basic SCSEP operations. The experimental projects served those most likely to succeed quickly in the private sector, while SCSEP operations focus on those with greater needs for basic training and supportive services. Other experimental project operators reported that, to meet the needs of their local markets, they in effect became recruiting agents for private sector employers. This role was viewed as a complement to SCSEP because it expanded the employment services available to those older workers seeking full-time work.

Experimental project operators reported that several techniques which they found necessary for effective training under an experimental project were directly transferrable to their SCSEP projects. Many reported that they were applying several of these techniques to their SCSEP training:

- Placing emphasis on concrete forms of training, such as actual work as a home health aide, since many older workers "learn by doing";

- Training for jobs with specific employers in occupations that are considered acceptable and desirable by older workers and in keeping with their sense of dignity;
- Placing emphasis on the availability of placement assistance;
- Allowing flexibility in the pace of training, especially for older workers in the classroom or in their first job;
- Setting expectations for older workers that are challenging but not overwhelming; and
- Attempting to match needs of older workers with the needs of employers.

APPENDIX A

Location of 502(e) Experimental Projects

Program Years 1983 through 1985-86

PROGRAM YEAR 1983 (January 1 - June 30, 1983)

State Sponsors:
Alaska - Juneau
Delaware
Oregon - Portland
Pennsylvania
Texas - San Antonio

National Sponsors:

NCOA	Statewide, Arizona
	Los Angeles, California
	San Bernardino, California
	San Jose, California
	Joplin, Missouri
	Statewide, New Jersey
	Trenton, New Jersey
	Binghamton, New York
	Syracuse, New York
	Rochester, New York
	Parkersburg, West Virginia
Green Thumb	Petaluma, California
	Trenton, New Jersey
	Oklahoma City, Oklahoma
	Sioux Falls, South Dakota
	Ashland City, Tennessee
	Salt Lake City, Utah
NCSC	Denver, Colorado
	Washington, D.C.
	Ft. Lauderdale, Florida
	Ft. Myers, Florida
	Miami, Florida
	Baltimore, Maryland
	Lansing, Michigan
	St. Paul, Minnesota
	Youngstown, Ohio
NUL	Hudson County, New Jersey
	Richmond, Virginia

(See key at end of Appendix)

PROGRAM YEAR 1983-84 (July 1, 1983 - June 30, 1984)

State Sponsors:

* Alaska - Juneau
Arkansas - Hot Springs
- North Little Rock
* Delaware - New Castle
Missouri - Jefferson City
New York - Broome County
Fulton County
Genesse County
Monroe County
Rockland County
New York City
Putnam County
* Oregon - Portland
* Pennsylvania
Tennessee
* Texas - Waco

National Sponsors:

NCOA	Huntsville, Alabama
	* Los Angeles, California
	* Trenton, New Jersey
	* Binghamton, New York
	* Syracuse, New York
	* Rochester, New York
	Research Triangle, North Carolina
	Lorain, Ohio
	Cincinnatti, Ohio
	San Antonio, Texas
	St. Albins, Vermont
	* Parkersburg, West Virginia
Green Thumb	* Petaluma, California
	Eldorado, Illinois
	McPherson, Kansas
	Great Falls, Montana
	Lincoln, Nebraska
	* Oklahoma City, Oklahoma
	Salem, Oregon
	* Ashland City, Tennessee
NCSC	Tuscaloosa, Alabama
	Orange County, California
	Bristol, Connecticut
	Ville Platte, Louisiana
	New Bedford, Massachusetts
	Ann Arbor, Michigan
	Pontiac, Michigan
	Gulfport, Mississippi

(See key at end of Appendix)

(PY 1983-84, Continued)

NCSC (Cont.)	Ashtabula, Ohio
	Knoxville, Tennessee
	Martin, Tennessee
	Memphis, Tennessee
NUL	* Hudson County, New Jersey
	* Richmond, Virginia
NCBA	Atlanta, Georgia
	Chicago, Illinois
	Mound Bayou, Mississippi
	Raleigh, North Carolina
	Nashville, Tennessee
ANPPM	Los Angeles, California
	Miami, Florida
	New Orleans, Louisiana
	Oklahoma City, Oklahoma
Forest Service	Albuquerque, New Mexico
	Pisgah Forest, North Carolina
	Franklin, North Carolina
	Yachats, Oregon
	Salt Lake City, Utah

(See key at end of Appendix)

PROGRAM YEAR 1984-85 (July 1, 1984 - June 30, 1985)

State Sponsors:
** Alaska - Juneau
* New York - Broome County
* - Fulton County
* - Genesse County
* - Monroe County
* - Rockland County
* - New York City
** Oregon - Portland
** Pennsylvania

National Sponsors:

NCOA
* Huntsville, Alabama
** Binghamton, New York
** Rochester, New York
** Syracuse, New York
New York, New York
* Research Triangle, North Carolina
* Cincinnati, Ohio
* San Antonio, Texas
* St. Albins, Vermont
** Parkersburg, West Virginia

Green Thumb
Hanceville, Alabama
* McPherson, Kansas
Wadena, Minnesota
* Oklahoma City, Oklahoma

NCSC
Fresno, California
Modesto, California
* Orange County, California
Pueblo, Colorado
Chicago, Illinois
* Ville Platte, Louisiana
Flint, Michigan
Ypsilanti, Michigan
New York, New York
Wilkes-Barre, Pennsylvania
Riverside, Rhode Island
Chattanooga, Tennessee
Green Bay, Wisconsin

NUL
** Hudson County, New Jersey
** Richmond, Virginia

(See key at end of Appendix)

(PY 1984-85, Continued)

NCBA	Birmingham, Alabama
	Defuniak Springs, Florida
	* Atlanta, Georgia
	* Chicago, Illinois
	* Mound Bayou, Mississippi
	* Raleigh, North Carolina
	Philadelphia, Pennsylvania
	* Nashville, Tennessee
Forest Service	Colorado (2 projects)
	Wayne Hoosier National Forest, Indiana
	* Albuquerque, New Mexico
	* Franklin, North Carolina
	* Pisgah Forest, North Carolina
	* Salt Lake City, Utah

(See key at end of Appendix)

PROGRAM YEAR 1985-86 (July 1, 1985 - June 30, 1986)

State Sponsors: *** Alaska
Indiana
Massachusetts
** New York - Broome County
** - Fulton County
** - Genesse County
** - Monroe County
** - Rockland County
** - New York City
*** Oregon

National Sponsors:

NCOA
** Huntsville, Alabama
*** Binghamton, New York
*** Rochester, New York
*** Syracuse, New York
* New York, New York
* Research Triangle, North Carolina
* Cincinnati, Ohio
* San Antonio, Texas
* Statewide, Vermont
*** Parkersburg, West Virginia
* Petersberg, West Virginia
Buckhannon, West Virginia
Huntington, West Virginia

Green Thumb
Jacksonville Beach, Florida

NCSC
Dothan, Alabama (2 projects)
* Modesto, California
Oakland, California
** Orange County, California
New Haven, Connecticut
Ft. Lauderdale, Florida
Bellville, Illinois
* Chicago, Illinois (2 projects)
Rock Island, Illinois
Waukegan, Illinois (2 projects)
* Ville Platte, Louisiana
Somerville, Massachusetts (2 projects)
South Dennis, Massachusetts
Baltimore, Maryland (2 projects)
Ann Arbor, Michigan
Battle Creek, Michigan
Detroit, Michigan
* Flint, Michigan

(See key at end of Appendix)

(PY 1985-86, Continued)

NCSC (Cont)		Pontiac, Michigan
	*	Ypsilanti, Michigan
		Chautauqua, New York
	*	New York, New York
		Akron, Ohio (2 projects)
		Erie, Pennsylvania
	*	Wilkes-Barre, Pennsylvania (2 projects)
	*	Chattanooga, Tennessee
		Knoxville, Tennessee
		Houston, Texas
		Port Arthur, Texas
	*	Green Bay, Wisconsin
NCBA	*	Birmingham, Alabama
	*	Defuniak Springs, Florida
	**	Atlanta, Georgia
	**	Chicago, Illinois
	**	Mound Bayou, Mississippi
	**	Raleigh, North Carolina
	*	Philadelphia, Pennsylvania
AARP		Puerto Rico

Key:	*	Project continued from prior year.
	**	Project continued from prior two years.
	***	Project continued from prior three years.

Appendix B

National Sponsors of Experimental Projects

American Association of Retired Persons

Mr. Glenn Northup, National Director
Senior Community Service Project
1909 K Street, N.W.
Washington, D.C. 20049
(202) 662-4800

Asociacion Nacional Pro Personas Mayores

Ms. Carmela G. Lacayo
National Executive Director
2727 West Sixth Street, Suite 270
Los Angeles, CA 90057
(213) 487-1922

Green Thumb, Inc.

Mr. Alec G. Olson
Administrator
5111 Leesburg Pike, Suite 107
Falls Church, VA 22014
(703) 820-4990

National Caucus and Center on Black Aged

Mr. Lawrence Crecy
Director
Rural Senior Employment Program
1424 K Street, N.W., Suite 500
Washington, D.C. 20005
(202) 637-8413

National Council on the Aging

Mr. Donald L. Davis
National Director
Senior Community Service Project
600 Maryland Avenue, S.W., West Wing 100
Washington, D.C. 20024
(202) 479-1200

SCSEP National Sponsors (Continued)

National Council of Senior Citizens

Mr. Ernest Post
Deputy Director
Senior AIDES Program
925 - 15th Street, N.W.
Washington, D.C. 20005
(202) 347-8800

National Urban League

Ms. Janet Zobel
National Director
Seniors in Community Service Program
500 East 62nd Street
New York, NY 10021
(212) 310-9202

U.S. Forest Service

Ms. Barbara M. Passuth
Project Director, SCSEP
Human Resource Programs
PO Box 2417, Auditors Building
Washington, D.C. 20013
(202) 382-1703

Senator MATSUNAGA. Thank you very much.

Ms. Crow, what would be the effect on the individual States if your proposal to change the way elderly commodity funds are distributed is accepted?

Ms. CROW. Well, we think the major effect on them would be to provide the States and the local project sites who have to depend on this subsidy a level of certainty in their funding.

Now, in terms of what effect it would have on them as to the amount of cash that they will receive in a given year, that would depend upon how many meals were served in the preceding year within that State and how much money was authorized and appropriated for the fiscal year in question.

Because of the way the data is collected, we have to look one year backwards, so the grant amount would depend on how much the State had served, in terms of number of meals within the State, proportionate to all the other States, and then the amount of money that was available would be divided accordingly. Each State would then receive at the beginning of the year a fixed grant.

Senator MATSUNAGA. Would there not be an inclination on the part of States to transfer funds between nutrition programs and other Title III-supported services under your proposal?

Ms. CROW. Well, I believe there are some barriers under the legislation for them doing that as USDA's proposal would require States to pass all of our payments on to local meal providers. Accordingly, no USDA funds could be transferred to other Title III-supported services.

Senator MATSUNAGA. Well, would that be good or bad?

Ms. CROW. Well, I think it is important for the people who are program managers to know how much funding they are going to be given at the beginning of the year out of any particular source of funding—in this case, the USDA subsidy support for these congregate and home delivered meals.

Given that amount of money and knowing that amount in advance, they can act accordingly or they can take steps to supplement that money. At least they would know with certainty where they were going, as regards that source of money, within any given year. We think that is an enormous improvement compared to having to wait until months after a fiscal year to know with any certainty how much you are going to get on a per-meal reimbursement rate.

Senator MATSUNAGA. Well, thank you very much. If there are any other questions, we will submit them in writing to you and you may submit your answers for the record in writing.

Ms. CROW. We appreciate that, Mr. Chairman. Thank you.

Mr. JONES. Thank you, Mr. Chairman.

Senator MATSUNAGA. Thank you very much, all of you.

Our next panel of witnesses today will be presenting testimony on issues which cut across the various titles of the Older Americans Act. We have Ms. Kathryn Dusenberry, who will be representing the National Council on Aging, which was created by the Older Americans Act and is charged with, among other things, making recommendations to the President and to Congress with respect to the federal policies regarding aging.

We have Ms. Eleanor Lloyd, who is the Director of the Kauai Area Agency on Aging, who will be speaking on behalf of the National Association of Area Agencies on Aging. I wish to thank Ellie for having come all the way from my native island of Kauai where I was born and for sacrificing the beautiful weather out there and prolonging her stay to be with us today here in Washington.

We have Ms. Wilda Ferguson, who is here today in her capacity as President of the National Association of State Units on Agency. She is also the Commissioner of the Virginia State Department of Aging.

Then we have Mr. Donald Reilly, who will be speaking on behalf of the National Council on Aging. Mr. Reilly is a Senior Vice President of NCOA.

Ms. Dusenberry, we will be happy to hear from you first.

STATEMENTS OF KATHRYN DUSENBERRY, COUNCIL MEMBER, FEDERAL COUNCIL ON AGING, TUCSON, AZ, ACCOMPANIED BY PETE CONROY, EXECUTIVE DIRECTOR; ELEANOR LLOYD, DIRECTOR KAUAI COUNTY OFFICE OF ELDERLY AFFAIRS, KAUAI, HI, ON BEHALF OF THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING; WILDA FERGUSON, PRESIDENT, NATIONAL ASSOCIATION OF STATE UNITS ON AGING, RICHMOND, VA; AND DONALD F. REILLY, SENIOR VICE PRESIDENT, NATIONAL COUNCIL ON THE AGING, INC., WASHINGTON, DC

Ms. DUSENBERRY. Good afternoon, Senator. My name is Katie Dusenberry and I come from Tucson, Arizona, not quite as far away as Hawaii. I am Chairman of the Federal Council on Aging Older Americans Act Reauthorization Committee, and I have brought with me this afternoon our Executive Director of the Federal Council, Pete Conroy.

Senator MATSUNAGA. You are welcome, Mr. Conroy.

Ms. DUSENBERRY. The Council members appreciate the opportunity to present testimony before this Committee regarding the renewal of legislation that has been and continues to be very important to this country's older citizens.

The Council delivered to all the relevant House and Senate committees the copies of our recommendations on the 1987 reauthorization of the Older Americans Act very early on in this 100th Congress session, and we ask that it be made a part of the Council's written testimony this afternoon.

Senator MATSUNAGA. Without objection, it is so ordered.

Ms. DUSENBERRY. Thank you.

This afternoon, rather than detail the recommended language changes and the Federal Council members' reasons for said changes, I will briefly enumerate the overarching issues that the Federal Council on Aging sees this Committee and its House counterpart facing in this year's Older Americans Act reauthorization process.

As our mandate in the Act states, we will make recommendations concerning these issues, and they are as follows. Number one, the Older Americans Act is now old enough and the network that administers it is mature enough for a longer authorization period than three years. Our recommendation speaks to an authorization of five years.

Number two, there should be no language added to the Act which gives the least hint of a means test. Number three, though every commissioner on aging has had and will continue to have a personal style of administering the Older Americans Act, there must be no language in the Act which encumbers how the commissioner carries out this mandate, save solely those arrived at through direct counseling, and I underline the word "direct," with the Secretary of Health and Human Services.

Number four, the current Title VII added to the 1984 reauthorization, but unfunded, has outlined worthwhile goals regarding the promotion of a healthier lifestyle for Americans 60 years and older. Most, if not all, of Title VII can be administered under Title III, providing some added funding is appropriated by Congress for these activities.

Number five, a clear and unhampered call in all relevant Older Americans Act titles should be given for participation of the private, for-profit segment of our economy.

Number six, the ombudsman program, which you alluded to in your opening statement and is detailed in Title III of the Older Americans Act, should call for more funding by the States and accentuate particularly, training requirements to be administered by the States.

Number seven, authorizing and appropriation committees should avoid too detailed a mandate within the Older Americans Act regarding health care and medical research. Specifics in these two important areas affecting the quality of life for older Americans is best left to those agencies, institutes, foundations, and private corporate research that are either presently mandated or market-oriented to such matters.

Number eight, though inter-agency memoranda of understanding have long been a formality between federal government agencies, the increased part being played by both State and local governments in serving older American needs calls for greater scope oversight and emphasis for Section 203 of the Older Americans Act, which deals with those inter-agency cooperative measures.

Number nine, a clearer understanding—and this goes back to Ms. Crow's remarks—a clearer understanding in the use of surplus commodities in the Older Americans Act Title III-C nutrition projects for the elderly is needed if we want commodities to continue to be a viable part of the Older Americans Act.

Number ten, the strength of the Older Americans Act rests with its flexibility which allows States and communities to use and adjust their service delivery to the conditions and the requirements of its older citizens.

Now, with the States, communities and private sector taking on an even larger funding and administrative role in social service programs, this flexibility in the Older Americans Act is even more important and should be emphasized in the 1987 reauthorization legislation.

I brought an exhibit with me today which demonstrates the long list of services that are covered by the area agencies throughout our country. One side of the page is a pie-shaped diagram of one particular area agency in Pennsylvania. The reverse side deals with the national average and the percentage of funds that are given to each one of the services.

Thank you, Mr. Chairman. This concludes my testimony and I would be very pleased to answer any questions that you might have.

[The prepared statement of Ms. Dusenberry follows:]

HEARING

TESTIMONY GIVEN BY THE FEDERAL COUNCIL ON THE AGING ON THE NEED FOR CHANGES IN CURRENT SERVICES UNDER THE OLDER AMERICANS ACT

BEFORE THE SENATE SUBCOMMITTEE ON AGING
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

April 30, 1987
Room 430
Dirksen Senate Office Building
Washington, D.C.

Witness Representative for the
Federal Council on the Aging:

Kathryn Dusenberry
Tucson, Arizona

Opening Statement and Testimony by
Kathryn Dusenberry
for the
Federal Council on the Aging

Good ~~morning~~ afternoon, Senator Matsunaga and members of the Aging Subcommittee of the Senate Labor and Human Resources Committee.

My name is Kathryn Dusenberry of Tucson, Arizona. I am Chairman of the Federal Council on the Aging Older Americans Act Reauthorization Committee. The Council members appreciate the opportunity to present testimony before this committee regarding the renewal of legislation that has been and continues to be very important to this country's older citizens.

The Council delivered to all the relevant House & Senate Committees, copies of its Recommendations on the 1987 Reauthorization of the Older Americans Act early in this session of the 100th Congress and we ask that it be made a part of the Council's written testimony this ~~morning~~ afternoon.

This ~~morning~~ afternoon, rather than detail the recommended language changes and FCoA members reasons for said changes, I will briefly enumerate the overarching issues that the Federal Council on the Aging sees this Committee and its House counterpart facing in this year's OAA reauthorization process. As our mandate in the Act states, we will make recommendations concerning these issues. They are as follows:

1. The Older Americans Act is old enough and the network that administeres it is mature enough for a longer authorization period than 3 years.

2. There should be no language added to the Act which gives the least hint of a means test.

3. Though every Commissioner on Aging has had, and will continue to h ave a personal style of administering the Older Americans Act, there must be no language encumbrances in how a Commissioner carries out this mandate, save solely those arrived at through direct counselling with the Secretary of Health and Human Services.

4. The current Title VII added in the 1984 Reauthorization but unfunded has outlined worthwhile goals regarding the promotion of a healthier lifestyle for Americans 60 years and older. Most, if not all, of Title VII can be administered under Title III providing some added funding is appropriated by Congress for these activities.

5. A clear and unhampered call in all relevant OAA Titles should be given for participation of the private, for profit, segment of our economy.

6. The Ombudsman program detailed in Title III of the OAA should call for more funding by the States and accentuate training requirements to be administered by the States.

7. Authorizing and Appropriations Committees should avoid too detailed a mandate within the Older Americans Act regarding health care and medical research. Specifics in these two important areas affecting the quality of life for older Americans is best left to those agencies, institutes, foundations, and private corporate research that are either presently mandated or market-oriented to such matters.

8. Though interagency memoranda of understanding have long been a formality between Federal government agencies; the increased part being played by State and local governments in serving older Americans needs, calls for greater scope oversight and emphasis for Section 203 of the OAA.

9. A clearer understanding in the use of surplus commodities in OAA Title III-C, Nutrition Projects for the Elderly (NPE,) is needed if commodities are to continue as a viable part of the OAA.

10. The strength of the Older Americans Act rests with its flexibility which allows States and communities to use and adjust their service delivery to the conditions and requirements of its older citizens. Now, with the States, communities and the private sector taking on a larger funding and administrative role in social service programs, this flexibility in the OAA is even more important and should be emphasized in the 1987 Reauthorization legislation.

Thank you, Mr. Chairman, that concludes my testimony this morning. I will be glad to answer questions if you or other members of the Committee so desire.

FEDERAL COUNCIL ON THE AGING

RECOMMENDATIONS ON THE 1987 REAUTHORIZATION OF THE OLDER AMERICANS ACT

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

The Federal Council on the Aging is pleased to submit its recommendations for amending the Older Americans Act during the 1987 reauthorization period.

A rapidly increasing aging population and limited resources have presented us with unique challenges in attempting to meet the needs of older Americans. While most older persons are comparatively healthy and active, a significant number require varying degrees of supportive services in order to cope with the demands of daily community living. Families, neighbors, and the State and Area Agencies on Aging, as well as others involved with aging concerns and services, have responded to this wide diversity of need. It is of paramount importance, however, that the aging network continue to be supported and strengthened in order that it may meet the challenges of the future. The Council's recommendations reflect this support in calling for increased discretion for the network.

The Council has long held a special concern for the "frail elderly," those most vulnerable members of the aging population. Our current recommendations continue to emphasize this concern by addressing the issue of targeting resources to those in "greatest economic or social need." Older Americans who are minorities, low income, women, disabled, live alone or live in rural areas are most likely to be or to become vulnerable than other older persons and, therefore, should be targeted at the local level within the parameters of the circumstances and resources of the community.

The Council appreciates the support and concern provided to older Americans and presents these recommendations for your consideration and response.

Respectfully submitted,

Ingrid C. Azvedo
Chairman

Enclosure

SUMMARY

The Federal Council on the Aging (FCA) urges the extension and reauthorization of the Older Americans Act (OAA) for a period of five years. While in complete support of the intent and purposes of the OAA, the FCA recommends a number of changes that will strengthen the purposes and objectives of this legislation and enhance services to older Americans.

The great diversity present in the aging population dictates a broad range of options in responding to and defining the parameters of need of these individuals. As individual capacities and vulnerabilities are considered, it becomes apparent that resources must be better targeted to approach most effectively the differences in level of need. Resources are not unlimited and those with the greatest need must be of greatest concern.

Needs of individuals are most appropriately determined within the circumstances of the community in which they reside. Although it is possible to identify generally characteristics that may indicate vulnerability of an older individual, these separate characteristics will not apply in each and every community. Therefore, it is the responsibility of those in a position to understand the capacities and constraints of a community to define the needs to be addressed in that community.

The FCA encourages regular incremental increases of 5 percent to assure adequate funding levels for all the Titles of the OAA. Each of the components of the OAA is a vital part of the whole and none should be sacrificed if the needs of older Americans are to be addressed in an effective and comprehensive manner.

The Federal Council believes that contributions based on ability to pay should be an integral part of Older Americans Act programs. However, the Council feels strongly that means testing should not be used to establish eligibility or amount of contribution. The Council has learned that in several regions of the country a voluntary sliding fee scale has worked well for requested services.

The OAA was intended to stimulate the development of a comprehensive, coordinated approach to the diverse needs of the older population. The FCA believes that the coordination of programs and services of both the public and private sector is vital to improving the quality of our country's response to the concerns of our aging population. To take full advantage of all segments of the community, the Council has asked that some restrictions on for-profit organizations be removed from OAA language.

BACKGROUND

Congress has charged the Council with the responsibility to "review and evaluate, on a continuing basis, Federal policies regarding the aging and programs and other activities affecting the aging. . ." It is, therefore, incumbent upon the FCA to carefully examine the current issues regarding the reauthorization of the Older Americans Act. Aware of this responsibility, the Council has undertaken a review of the issues raised by the Administration, the national aging network and organizations, the private sector, other State and local governmental entities, and the general public.

The OAA has been amended ten times since its inception. Provisions of the original legislation were extended in 1967. The 1969 amendments strengthened the Title III community services programs and charged the State Agencies on Aging with Statewide responsibilities for planning, coordination, and evaluation of programs for older persons. The 1972 amendments created national nutrition programs and authorized grants to public and nonprofit sponsors for the development of congregate meal services. The creation of the Area Agencies on Aging was mandated by the 1973 amendments in addition to the creation of the National Information and Resource Clearinghouse for the Aging and the Federal Council on the Aging. Amendments made in 1974, 1975, and 1977 primarily extended the authority for continued program operation, and made a number of minor adjustments to the Act. The 1978 amendments further strengthened and expanded Title III of the Act by consolidating the social services, multipurpose senior center, and nutrition services portion of the Act. A separate Title, Title VI, authorizing grants for Indian tribes, was established. In addition, a separate authorization for home-delivered meals was made under Title III. Since the 1981 and 1984 amendments primarily extended the programs and made only minor changes, the 1987 reauthorization period is a time for careful review and amending to update the Act.

The following pages detail the Council's recommendations for amending the OAA in 1987. Some of the recommendations contain extensive rewording and redirection while other recommendations seek to strengthen existing language or to emphasize areas that the Council finds of particular importance.

TITLE I

Title I sets forth the objectives of the OAA. Ten broad goals are outlined toward giving older persons opportunities for participation in the full life of the community. These goals are: an adequate income; physical and mental health; suitable housing; full restorative services for those who require institutional care; employment without age discrimination; retirement in health, honor, and dignity; participation in civic, cultural, and recreational activities; efficient community services; benefit from research designed to sustain and improve health and happiness; and freedom to plan and manage their lives.

Recent emphasis on increasing the efficiency and effectiveness of service provision dictates a systematic approach to the above listed goals and the development of a continuum of care concept. Long-term care no longer refers just to the institutional care of the chronically ill. There is now great concern with the prevention of institutionalization and with the provision of supportive services in the community to maintain the individual in the home for as long as is feasible.

1. POLICY

The Council feels that one additional Title I objective should be added to deal with elder abuse and exploitation.

Language Change

Insert the following as item (11) under section 101.

> (11) Freedom from abuse, neglect and exploitation in all aspects of daily living.

2. POLICY

With longevity resulting in more multi-generation families, the Council feels that Title I should enumerate services to and consideration for the family caregiver.

Language Change

> (12) Support to family members and others providing voluntary care to those older citizens needing long-term services.

3. POLICY

The Council is aware that a more concise definition of the term "rural" is necessary as this has been an ongoing troublesome problem in the administration of the Older Americans Act.

Language Change

Insert the following as item (8) under section 102.

> (8) The term "rural" should be determined in all matters of the Act as defined by the Bureau of the Census.

TITLE II

Title II establishes the Administration on Aging (AoA) within the Department of Health and Human Services (DHHS) as the principal agency for carrying out the purposes of the OAA and administration of the grant programs authorized under the Act. It is the part of the Act which discusses the establishment of the functional units necessary to implement the Act, including the Federal Council on the Aging.

Organizationally, the AoA is located within the Office of Human Development Services (OHDS) in DHHS. Congress intended that the AoA was to serve as an effective advocate on all Federal activities and matters related to the field of aging. With increasingly complex and enlarged programs impacting on the elderly, more demands and pressures are placed on the AoA to perform its advocacy, as well as program administration functions.

4. POLICY

The Council urges the Secretary of the DHHS, to provide the maximum support possible to the Commissioner on Aging in carrying out the mandates contained in the OAA. This includes the strengthening of the Commissioner's decisionmaking authority, flexibility, and visibility within the Federal establishment and the aging network wherever and whenever possible and feasible.

Language Change

Delete from Section 201(a) the words in line 7 and line 9

"the Office of."

5. POLICY

Extending the reauthorization period to five rather than the customary three years reflects the refined state of this legislation. The Council feels the longer authorization period will allow for efficiency in program management. The Council also feels that a longer reauthorization period will allow for substantive changes without the trauma of total reauthorization. To facilitate the five year authorization, the Federal Council recommends the following language change.

Language Change

Insert the phrase, ", and such sums as may be necessary for the fiscal years 1988 through 1992" at the following places throughout the Act:

In Sec. 204(g), between "1987" and the period;
In subsections (a) and (b) of Sec. 303, between "1987" and "for;"
In Sec. 311(c)(1)(A), between "1987" and "to carry out;"
In Sec. 431(a), between "1987" and the period;
In Sec. 508(a)(1), between "1987" and the semicolon;
In Sec. 608(a), between "1987" and "to carry out."

Strike "and 1987" in Sec. 706(a), and substitute for it, ", 1987, 1988, 1989, 1990, 1991, and 1992."

6. POLICY

The Council feels an important role in its responsibilities is to nurture interagency cooperation among the various Federal departments which oversee programs dealing with the elderly.

Language Change

Insert new paragraph under section 204(d).

(6) Act as coordinator to bring together and improve working relationships between all Federal Departments and agencies that deliver services or programs to older Americans.

7. POLICY

Given the demographics of aging, the Council feels that input from its members serving on advisory boards of these Federal agencies or departments listed in the Act's Sec. 203, could provide valuable gerontological information and viewpoint to such boards without infringing on their autonomy or the agencies or departments they serve.

Language Change

Insert new paragraph under section 204(d).

(7) provide membership on present or future boards or councils created by those departments or agencies listed under Section 203 of this Act.

TITLE III

Title III authorizes grants to State Agencies on Aging for developing a comprehensive and coordinated delivery system of supportive social services, nutrition services, and multipurpose senior centers. The Title III organizational structure is intended to form a "network on aging" linking the AoA, State and Area Agencies on Aging, other public and private agencies, and local service providers. This network is intended to provide the focal point for a continuum of community services as well as social and economic opportunities for older persons.

Research and program experience have provided a much more diverse picture of older persons than the stereotype of dependency and helplessness that has prevailed in the past. Most older persons are healthy, active, and involved with family and community. Presuming that these individuals are no longer capable of functioning in society when they reach age 60 or 65 denies their humanity and denies society an immeasurable pool of capabilities and human resources. For these individuals with widely varied interests and concerns, opportunities are needed to allow and encourage participation in the mainstream of community life. During this period emphasis should be placed on education and implementation of preventive measures which will retard and delay need for intensive dependent care.

While the majority of older persons function adequately on a day-to-day basis, there are individuals who have become frail and, therefore, vulnerable to the stresses and demands of daily living. The various elements which contribute to this vulnerability differ widely from individual to individual and from one geographic area to another. For these diverse reasons, the responsibility to define their needs should remain as close to the individuals as possible.

Underlying the diversity of older persons and their circumstances, certain factors have been identified as indicating possible vulnerability--income, race, education, health, and sex. Recent research indicated that other factors, such as living alone or the general mortality rate in the geographic area, may also reflect vulnerability. Age, however, does not significantly correlate with vulnerability or frailty. The wide diversity among older persons and the great range in their needs calls for an approach to service provision that allows for maximum flexibility and provides responsiveness to individual circumstances.

It is virtually impossible for Federal legislation and regulation to be sufficiently specific to efficiently target resources and, concurrently, be adequately responsive to the needs of individuals in various communities. However, national priorities can be set which local entities may then address within the context of community needs and resources. The 1978 amendments to the Older Americans Act began identifying these national priorities by giving preference in the provision of services under Title III to those "with the greatest economic or social need." The 1984 amendments began the process for more flexibility in the use of Title III funds by allowing much more discretion for appropriately responding to the individual needs within the community.

EMPHASIZING FOR PROFIT ORGANIZATIONS

8. POLICY

The Council feels that in all parts and titles of the Older Americans Act for profit organizations should be included in the language where their particpation may be a possibility.

Language Change

Sec. 301(a) add nonprofit and for profit organizations. . .

Sec. 302(1)(A) replace private with for profit or nonprofit agency or organizations.

Sec. 302(2) replace private with for profit or nonprofit agency.

AUTHORIZATION OF APPROPRIATIONS

9. POLICY

The Council feels that because current demographics portend a steady increase in the numbers of senior Americans and that Older Americans Act programs greatly benefit the socially and economically needy members of this age cohort, the current annual increment rate of funding should continue during the proposed five year reauthorization period. The Council recommends appropriation figures in Sec. 303 to reflect an annual incremental rate of at least 5 percent.

TARGETING

10. POLICY

The Council feels that some new language is needed to provide for better targeting of the vulnerable elderly and more flexibility for the Administration on Aging and State and Area Agencies on Aging to deal with targeting services to the vulnerable elderly by amending the Act as follows:

Language Change

Insert the following underlined language in Sec. 305(a)(2)(E) and Sec. 306(a)(5)(A):

> "provide assurances that preference will be given to providing services to older individuals with the greatest economic or social needs, with particular attention to low-income minority individuals, females, rural residents, those living alone, and functionally impaired or otherwise disabled, and include proposed methods of carrying out the preference. ."

Insert at the end of paragraph (1), Sec. 306(b) the following underlined language:

"(1) Each State, in approving area agency plans under this section, shall waive the requirement described in clause (2) of subsection (a) for any category of services described in such clause if the Area Agency on Aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area or may waive the requirements if the AAA demonstrates that funds which, would be used for such services, without the waiver, will be targeted and used for the vulnerable elderly.

Flexibility

11. POLICY

The Council feels that State and Area Agencies have matured to the point where maximum flexibility in the transfer of funds between parts B and C should be a part of the Act.

Language Change

Repeal paragraphs (4) and (5) of Sec. 308(b), and substitute therefor a new paragraph (4) to read as follows: (languge to be added is underlined; language to be stricken is shown ~~like this~~)

"(4) Notwithstanding any other provision of this title, with respect to funds received under section 303~~(b)(1) and (2)~~, a State may elect in its plan under section 307~~(a)(13) regarding part C of this title~~ to transfer a portion or all of the funds appropriated for part C between subpart 1 and subpart 2 of part C, or for use for part B supportive services, and may elect to transfer a portion or all of the funds appropriated for part B for use for part C, subpart 1 or subpart 2 nutrition services, ~~for use~~ as the Area Agencies consider appropriate to meet the needs of the area served subject to approval by the State Unit on Aging.. The Commissioner shall approve any such transfer unless the Commissioner determines that such transfer is not consistent with the purposes of this Act."

12. POLICY

The Council feels that any increase in Federal dollars is limited, therefore, it is necessary to facilitate the brokering role of Area Agencies on Aging, to assure that they, as community focal points in their respective communities, have the primary role in coordination of all community and family resources, and stimulation of the supplementary sources of funding and services, by amending the Act as follows:

Language Change

Add the following subparagraph to Sec. 306(a)(6):

> "(L) serve as a broker in activating and coordinating all existing and potential public, (emphasizing the local offices of those agencies enumerated in section 203(b)), private, community, and family resources to solve the problems of and take advantage of opportunities of the area's older individuals, by stimulating supplementary sources of funding and services for them with technical assistance from State agency."

13. POLICY

The Council has met with representative Native Americans tribal organizations and received extensive testimony on the needs of native American elders - evidence calls for relaxing restrictions on Title III services for Native Americans who are served by tribal organizations that apply for Title VI funds, by amending paragraph (3), Sec. 602(a) to read as follows: (language to be added is underlined)

> "(3) individuals to be served by the tribal organization will not receive for the year for which application under this title is made, services under Title III, unless the application is unsuccessful or a Title VI service comparable to a Title III service needed by an older Indian is not reasonably available for that older Indian."

14. POLICY

The Council welcomed the start made in the 1984 OAA amendments in referencing the demographics of aging in America - 1987 reauthorization language should accent most current demography, by amending the Act as follows:

Language Change

Repeal paragraph (2) of Sec. 304(a), which requires that each State be allotted as much under Title III as it received for fiscal year 1984.

15. POLICY

The Council feels that because added responsibilities were put on Area Agencies on Aging in past OAA Reauthorization and because the 1987 reauthorization will continue this trend, it is reasonable to increase the administrative cost of these local agencies.

Language Change

Section 304(d)(1)(A) such amount as the State agency determines but not more than 12.0 percent, therefore, shall be available for paying such percentage as the agency determines, but not more than 75 percent of the cost of administration of area plans.

16. POLICY

The Council is pleased with the active role presently being played by State Long-Term Care Ombudsmen. The Council recommends updating ombudsman language by amending the Act as follows:

Language Change

Amend subparagraph (B) of Sec. 304(d)(1) by adding the language underlined below:

"(B) such amount as the State agency determines to be adequate for conducting an effective ombudsman program under section 307(a)(12) shall be available for paying such percentage as the agency determines, but not more than 85 percent, of the cost of conducting such program;"

Redesignate clause (v) of Sec. 307(a)(12)(A) as clause (vi) and insert a new clause (v), as follows:

"(v) to the extent feasible, carry out, with respect to older individuals who receive home health services, activities of the type specified in clauses (i) through (iv); and"

17. POLICY

The Council understands that serious discussion is taking place to create a new Section 3D in Title III which would deal with ombudsman services and duties. The Council supports this initiative, however, feels that if added, such a section should include a statement standardizing qualifications, duties, and funding of the State Ombudsman Program.

18. POLICY

The Council feels that with the private sector playing an ever larger role in providing services, funds and volunteers to this country's seniors, in order to recognize intergenerational dependency and direct that educational and community efforts reinforce the bonding of the generations, the Act should:

Add to paragraph (6) of Sec. 306(a) a new subparagraph (L), as follows:

> "(L) promote educational and community efforts to reinforce the natural affinity and bonding between each community's older individuals and its children, youth and young adults."

Inserting into Sec. 321(a) a new paragraph (19)--and changing the designation of the present paragraph (19) to paragraph (20)--as follows:

> "(19) services to reinforce the bonding of generations; or"

19. POLICY

The Council feels to define the word "adequate" as the Congress has used it in the Older Americans Act will help to clarify and bring meaning and effect to the word "adequate" as used in paragraph (2) of Sec. 306(a), which paragraph requires that an adequate proportion of supportive services funds alloted to a planning and service area be used for named priority services, by:

Adding to Sec. 306 a new subsection (d), as follows:

> "(d)(1) Each State, in approving area agency plans under this section, shall determine whether such plans provide for spending an adequate proportion of funds as required by paragraph (2) of subsection (a).
>
> "(2) In determining adequacy for purposes of paragraph (2) of subsection (a), each State shall take into consideration the need for that type of service in planning and service areas and the need for using such funds for other services of greater benefit to the area's older individuals with the greatest economic or social needs.
>
> "(3) In the absence of abuse of discretion, as determined by the Commissioner, subject to judicial review, the State's determination under paragraph (1) shall be final."

20. POLICY

The Council has learned in certain jurisdictional affiliations the AAA director has been assigned duties other than those dealing with the Older Americans Act. Because of the importance of continuity in the administration of OAA programs the Council feels it is necessary to require the following language change:

Redesignate paragraph (6) of Sec. 306(a) as paragraph (7), and insert between paragraph (5) and the redesignated paragraph (7) a new paragraph (6), as follows:

> "(6) require that the director or other principal employee of the Area Agency on Aging be a full-time employee, devoting all his or her time and efforts as such employee exclusively to the work of the Area Agency on Aging."

TITLE IV

Title IV provides the authority to AoA to support efforts in training, education, research, demonstration, and evaluation which adds knowledge to improve program effectiveness and efficiency. The major activities undertaken in each of the Title IV program areas are designed to develop and disseminate information to assist decisionmakers and service providers in addressing issues concerning older persons.

Understanding the processes of aging and the changes to be expected in an aging society are essential in the development of efficient and effective services for older persons. The research, training, and education projects required to attain this understanding are designed and implemented through the policies and practices in business and industry, as well as the various colleges and universities engaged in the study of aging.

21. POLICY

The Council recommends strengthening language in order to emphasize the importance of research, training, education projects and demonstrations in both the academic and private business sectors. In addition, funding levels should be maintained commensurate with past appropriations, with specific allocations to all States, and sufficient to fulfill the charge of Title IV.

There should be a continuing effort to analyze, coordinate, and disseminate findings from completed and future research and evaluation projects in order to better utilize these findings.

Language Change

Amending Secs. 421, 422, and 423, to assure that Title IV grants, contracts, and cooperative agreements can be made under those sections to or with for-profit organizations on the same basis as they are made to or with public and private non-profit organizations.

Example: Amend Sec. 421(a) by striking language indicated ~~like/this~~:

> "SEC. 421. (a) The Commissioner may make grants to ~~any/public/or/nonprofit/private agency/ organization//or/institution/~~ and may enter into contracts with any agency, organization, institution, or individual to support research and development related to the purposes of this Act, evaluation of the results of such research and development activities, . . ."

TITLE V

Title V, Community Service Employment for Older Americans, mandates the creation of "useful part-time opportunities in community service activities" targeted to those "unemployed low-income persons who are fifty-five years of age or older and who have poor employment prospects." These programs differ from other Older Americans Act (OAA) programs in two significant ways. Title V programs are the only OAA programs to include a means-tested eligibility determination, and the administration of these programs falls under the auspices of the Department of Labor (DOL) rather than the Administration on Aging (AoA). Although various Title V programs differ with regard to the characteristics of participants, types of job placements, and geographic setting (rural or urban), each project shares the same basic goals of providing income and employment, offering training and opportunities for unsubsidized employment, and supplying public services to the community.

Currently, funding for the Title V programs is disbursed among eight national organizations (National Center on Black Aged, National Urban League, Asociacion Nacional Pro Personas Mayores, National Council on the Aging, American Association of Retired Persons, National Council of Senior Citizens, U.S. Forest Service, and Green Thumb-National Farmers Union) and the governors of the various States and territories.

22. POLICY

The Council recommends no changes in this Title.

TITLE VI

23. POLICY

The Council recommends one change in Title VI because the recommended addition of Title III as well as Title VI services to Native Americans appears to be the best way to broaden services to this segment of America's elderly cohort.

This decision was reached after numerous meetings between FCA and tribal elders and studying written testimony all of which indicates that tribal elders need the benefit of the advantages of both Title III and Title VI programs.

The proposed FCA changes in OAA language will require careful cooperation between AoA, AAAs and tribal councils representatives in the writing of regulations implementing such changes should they become law in 1987.

Language Change

Relax restrictions on Title III services for Native Americans who are served by tribal organizations that apply for Title VI funds, by amending paragraph (3), Sec. 602(a) to read as follows: (language to be added is underlined). Additional, recommendations for services to Native Americans are referenced under the Title III section in this document.

> "(3) individuals to be served by the tribal organization will not receive for the year for which application under this title is made, services under Title III, unless the application is unsuccessful or a Title VI service comparable to a Title III service needed by an older Indian is not reasonably available for that older Indian."

TITLE VII

24. POLICY

The Council supports the thrust of the new Title VII. However, it has come to the Council's attention that in carrying out programs mandated under this Title, States and Area Agencies have been forced to use Title III funds. Council suggests that Congress appropriate funds as authorized for this Title or increase Title III funds accordingly.

MEMBERS OF THE FEDERAL COUNCIL ON THE AGING

Ingrid C. Azvedo, Chairman of the Federal Council on the Aging, and Advocate for seniors programs, Elk Grove, CA.

Nelda L. Barton, President and Chairman of the Board, Health Systems Inc., Corbin, KY.

Oscar P. Bobbitt, Executive Director, Texas Department on Aging, Austin, TX.

Edna Bogosian, Principal Insurance Examiner, Divison of Banking & Insurance, Commonwealth of Massachusetts, Boston, MA.

James N. Broder, Esquire, Curtis, Thaxter, Stevens, Broder & Micoleau, Portland, ME.

Kathryn Dusenberry, Business Executive and Former Member of Pima County Board of Supervisors, Tucson, AZ.

D. Antonio Guglielmo, Owner & Manager, Penny-Henley and Howley Insurance Company, Stafford Springs, CT.

Jon B. Hunter, Director, Region VI Area Agency on Aging, Fairmont, W. VA.

Frances S. "Peg" Lamont, State Senator, Aberdeen, S.D.

Tessa Macaulay, Consumer Affairs, Florida Power & Light Company, Miami, FL.

Mary E. Majors, Private Citizen and Volunteer Programs, Cedar Falls, Iowa

Russell C. Mills, Ph.D., Long Term Care Gerontology, Center, Mission Hills, KS.

Josephine K. Oblinger, Director of Senior Involvement, in the Office of Governor James R. Thompson, Springfield, IL.

Edna "Bonny" Russell, Ed.D., Retired Director, Education & Training, San Jose State University, Atherton, CA.

Albert Lee Smith, Jr., Former U.S. Congressman, and Positive Maturity-Retired Senior Volunteer Program, Birmingham, AL.

REAUTHORIZATION COMMITTEE

Kathryn Dusenberry, Chairperson
Jon B. Hunter
Ingrid C. Azvedo, Ex-Officio

Senator Matsunaga. You were most efficient; you finished before the red light.

Ms. Dusenberry. I talk fast.

Senator Matsunaga. Thank you very much.

Our next witness, I forgot to mention earlier, is accompanied by the program specialist on aging from the Hawaii Executive Office on Aging, and I would like her to stand up and be recognized, Ms. Evelyn Chong.

[Ms. Chong stood.]

Senator Matsunaga. Thank you for coming. She comes all the way from paradise, too.

We would be happy now to hear from you, Ellie.

Ms. Lloyd. Thank you, Senator Matsunaga. I would like to say that I am pleased that you scheduled this hearing at this time, as I was back attending an NAAAA board meeting, as was Ms. Chong attending a NASUA board meeting. Otherwise, I know my mayor, running a very tight ship as far as budgets, would not have allowed me to travel this far. So thanks to you.

As you know, I am the Director of the Kauai County Office of Elderly Affairs in Hawaii on the island of Kauai, and I am also a member of the board of directors of the National Association of Area Agencies on Aging, NAAAA, which represents the boards, the advisory councils, service providers and staff of over 670 area agencies on aging nationwide.

I am very proud to have resided on our Chairman's island of Kauai for 25 years and having served in my present capacity as an area agency director for 15 years. I have a firm commitment toward serving our older citizens, and I thank you for giving our association this opportunity to appear before you, and particularly with our Senator Spark Matsunaga as Chairman.

Irregardless of our geographic distance from Washington, D.C., the reauthorization of the Act has far-reaching effects on the welfare of all older Americans across America. The increased number of older adults in society, combined with the changing characteristics of this population, will produce vast challenges to the quantity and quality of our service delivery systems in the future.

We look to your Committee to continue to support the successes of our network, but also to assist us in strengthening it through this reauthorization. We are seeking continued flexibility to determine the needs of our local communities, taking into consideration not only the growing number of elderly persons who have unmet needs, but also the supply of our services and the community resources which enable us to support these critical services.

Our National Association of Area Agencies on Aging is striving diligently to maintain a strong network at the federal, State and local levels. We look toward the Administration on Aging to advocate for the maximum options for all older Americans.

We need our State units on aging to continue to provide leadership and guidance in policies and procedures, and we view ourselves as area agencies in developing community-based services that are responsive to the needs of all of our elderly constituents.

In reviewing local progress toward developing a comprehensive, coordinated system of services for the elderly, we must remember that providing services requires resources. With adequate resources available, we are challenged to then develop flexible local systems. These systems, we work to make efficient. We also make sure that they are effective, and we also make sure that the resources on a local level are used appropriately.

Historically, by the early 1970s, concern began to grow about the health care emphasis on institutionalization, especially in nursing homes. Studies revealed that many nursing home residents did not have to be there if appropriate alternate community services were available.

This triggered amendments in the 1973 reauthorization of the Older Americans Act that provided funding for alternate community services and established the area agencies on aging, who would be the planners and coordinators of all community-based services.

The Title III mandate was for area agencies to establish comprehensive, coordinated systems of services for the aging, which would enable older people to live in their homes or in places of residence as long as possible.

To implement this mandate, we have developed a wide array of support services for our elderly population. In Attachment A of this testimony, I have also listed a listing of over 40 specialized services which are available within our State of Hawaii.

Incidentally, on our small island of Kauai we have no public transportation, so my office actually operates the only public transportation serving handicapped and elderly. Other States have similar services; some have more, others less, depending upon those resources available to them and the local circumstances and determination of priorities.

In several States, State units on aging and area agencies have developed solid systems serving the vulnerable elderly, drawing on the Older Americans Act, social services, block grants, Medicare, Medicaid, and many others, integrating through care management activities.

Care management and long-term care planning have been mandated by our State of Hawaii to be studied carefully. I have included a diagram here which shows how we are working in conjunction with our State agency to develop that by this September.

I would like to thank you for this opportunity to testify, and in closing I would like to tell you that an amendment is attached, and a resolution from our county council also commending you and your Committee.

[The prepared statement of Ms. Lloyd, with attachments, follows:]

NATIONAL ASSOCIATION OF
AREA AGENCIES ON AGING
"Reaching the Nation's Elderly"

STATEMENT OF

NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

PRESENTED BY ELLIE LLOYD, DIRECTOR

KAUAI COUNTY OFFICE OF ELDERLY AFFAIRS, HAWAII

BEFORE THE

SUBCOMMITTEE ON AGING

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

WASHINGTON, D.C.

APRIL 30, 1987

600 Maryland Avenue, S.W., Suite 208, Washington, D.C. 20024 (202) 484-7520

SENATOR MATSUNAGA AND MEMBERS OF THE SUBCOMMITTEE ON AGING, MY NAME IS ELLIE LLOYD, I AM THE DIRECTOR OF THE KAUAI COUNTY OFFICE OF ELDERLY AFFAIRS IN HAWAII. I AM ALSO A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING (NAAAA) WHICH REPRESENTS THE BOARDS, THE ADVISORY COUNCILS, SERVICE PROVIDERS AND THE STAFF OF OVER 670 AREA AGENCIES ON AGING NATIONWIDE.

I AM VERY PROUD TO HAVE RESIDED ON OUR CHAIRMAN'S ISLAND OF KAUAI FOR TWENTY-FIVE YEARS AND HAVING SERVED IN MY PRESENT CAPACITY AS AN AREA AGENCY DIRECTOR FOR FIFTEEN YEARS, I HAVE A FIRM COMMITMENT TOWARD SERVING OUR OLDER CITIZENS AND I THANK YOU FOR GIVING OUR ASSOCIATION THIS OPPORTUNITY TO APPEAR BEFORE YOU AND PARTICULARLY WITH OUR SENATOR SPARK MATSUNAGA AS CHAIRMAN OF THIS COMMITTEE.

IRREGARDLESS OF OUR GEOGRAPHICAL DISTANCE FROM WASHINGTON D.C., THE REAUTHORIZATION OF THE ACT HAS FAR REACHING EFFECTS ON THE WELFARE OF ALL OLDER AMERICANS ACROSS AMERICA. THE INCREASED NUMBER OF OLDER ADULTS IN SOCIETY, COMBINED WITH THE CHANGING CHARACTERISTICS OF THIS POPULATION WILL PRODUCE VAST CHALLENGES TO THE QUANTITY AND QUALITY OF OUR SERVICE DELIVERY SYSTEM IN THE FUTURE.

WE LOOK TO YOUR COMMITTEE TO CONTINUE TO SUPPORT THE SUCCESSES OF OUR NETWORK, BUT ALSO TO ASSIST US IN STRENGTHENING IT THROUGH THIS REAUTHORIZATION. WE ARE SEEKING CONTINUED FLEXIBILITY TO DETERMINE THE NEEDS OF OUR LOCAL COMMUNITIES, TAKING INTO CONSIDERATION NOT ONLY THE GROWING NUMBER OF ELDERLY PERSONS WHO HAVE UNMET NEEDS, BUT ALSO THE SUPPLY OF OUR SERVICES AND THE COMMUNITIES RESOURCES WHICH ENABLE US TO SUPPORT THESE CRITICAL SERVICES.

OUR NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING IS STRIVING DILIGENTLY TO MAINTAIN A STRONG NETWORK AT THE FEDERAL, STATE AND LOCAL LEVELS. WE LOOK TOWARD THE ADMINISTRATION ON AGING TO ADVOCATE FOR THE MAXIMUM OF OPTIONS FOR ALL OLDER AMERICANS. WE NEED OUR STATE UNITS ON AGING TO CONTINUE TO PROVIDE LEADERSHIP AND GUIDANCE IN POLICIES AND PROCEDURES AND WE VIEW OURSELVES AS AREA AGENCIES IN DEVELOPING COMMUNITY BASED SERVICES THAT ARE RESPONSIVE TO THE NEEDS OF ALL OF OUR ELDERLY CONSTITUENTS.

IN REVIEWING LOCAL PROGRESS TOWARD DEVELOPING A COMPREHENSIVE, COORDINATED SYSTEM OF SERVICES FOR THE ELDERLY WE MUST REMEMBER THAT PROVIDING SERVICES REQUIRES RESOURCES. WITH ADEQUATE RESOURCES AVAILABLE, WE ARE CHALLENGED TO THEN DEVELOP FLEXIBLE LOCAL SYSTEMS.

- THE SYSTEM MUST USE AVAILABLE RESOURCES AS EFFICIENTLY AS POSSIBLE, TO GET THE MOST RESULT FOR RESOURCES EXPENDED;
- THE SYSTEM MUST MAKE SURE SERVICES ARE EFFECTIVE, IN TERMS OF MAINTAINING FUNCTIONING AND SUPPORTING INDEPENDENCE; AND
- THE SYSTEM MUST MAKE SURE RESOURCES ARE USED APPROPRIATELY, BY TAILORING OVERALL SERVICE CAPACITY TO OVERALL SERVICE NEEDS AND BY MAKING SURE INDIVIDUAL ELDERLY PERSONS RECEIVE THE SPECIFIC SERVICES THEY NEED, IN THE PROPER COMBINATION, AT THE NEEDED INTENSITY, AND FOR THE PROPER DURATION.

HISTORICALLY BY THE EARLY 1970'S, CONCERN BEGAN TO GROW ABOUT THE HEALTH CARE EMPHASIS ON INSTITUTIONALIZATION, ESPECIALLY IN NURSING HOMES. STUDIES REVEALED THAT MANY NURSING HOME RESIDENTS DID NOT HAVE TO BE THERE, IF APPROPRIATE ALTERNATIVE COMMUNITY SERVICES WERE AVAILABLE. THIS TRIGGERED AMENDMENTS IN THE 1973 REAUTHORIZATION OF THE OLDER AMERICANS ACT THAT PROVIDED FUNDING FOR ALTERNATIVE COMMUNITY SERVICES AND ESTABLISHED THE AREA

AGENCIES ON AGING, WHO WOULD BE THE PLANNERS AND COORDINATORS OF ALL COMMUNITY BASED SERVICES. THE TITLE III MANDATE WAS FOR AREA AGENCIES TO "ESTABLISH COMPREHENSIVE, COORDINATED SYSTEMS OF SERVICES FOR THE AGING" WHICH WOULD "ENABLE OLDER PERSONS TO LIVE IN THEIR HOMES OR OTHER PLACES OF RESIDENCE AS LONG AS POSSIBLE".

TO IMPLEMENT THIS MANDATE, WE HAVE DEVELOPED A WIDE ARRAY OF SUPPORT SERVICES FOR OUR ELDERLY POPULATION. IN ATTACHMENT "A" OF THIS TESTIMONY I HAVE INCLUDED A LISTING OF OVER FORTY (40) SPECIALIZED SERVICES WHICH ARE AVAILABLE WITHIN OUR STATE OF HAWAII. OTHER STATES HAVE SIMILAR SERVICES; SOME HAVE MORE, OTHERS LESS, DEPENDING UPON THOSE RESOURCES AVAILABLE TO THEM AND THE LOCAL CIRCUMSTANCES AND DETERMINATION OF PRIORITIES.

IN SEVERAL STATES, STATE UNITS AND AREA AGENCIES ON AGING HAVE DEVELOPED SOLID SYSTEMS SERVING THE VULNERABLE ELDERLY, DRAWING IN OLDER AMERICANS ACT, SOCIAL SERVICES BLOCK GRANT, MEDICAID, MEDICARE AND/OR STATE AND LOCAL REVENUES, INTEGRATING THEM THROUGH CARE MANAGEMENT ACTIVITIES. WE WERE PLEASED THESE MODELS RECEIVED RECOGNITION OF THEIR SUCCESS THROUGH THE CONGRESSIONAL MANDATE OF THE 1984 REAUTHORIZATION WHICH INSTRUCTED AREA AGENCIES TO "FACILITATE THE COORDINATION OF COMMUNITY-BASED LONG-TERM CARE SERVICES... TO EMPHASIZE THE DEVELOPMENT OF CLIENT-CENTERED CASE MANAGEMENT SYSTEMS AS A COMPONENT OF SUCH SERVICES".

CARE MANAGEMENT AND LONG TERM CARE PLANNING HAS BEEN MANDATED BY OUR HAWAII STATE LEGISLATURE TO BE STUDIED CAREFULLY PRIOR TO IMPLEMENTING A STATE-WIDE PLAN BY THE STATE EXECUTIVE OFFICE ON AGING IN CONJUNCTION WITH THE COUNTY AREA AGENCIES ON AGING. WE ARE ALL WORKING IN CONCERT TO COMPLETE THIS DOCUMENT BY THIS SEPTEMBER 1987. (ATTACHMENT B)

IN A PERIOD WHERE WE SEE MAJOR GROWTH IN OUR "OLD-OLD" POPULATION, MAJOR CHANGES IN THE DRGS AND THE MEDICARE PROGRAM ARE PLACING NEW STRESSES ON THE COMMUNITY CARE SYSTEMS. RAPID GROWTH IS OCCURRING IN THE ENTIRE HEALTH CARE MARKET WITH NEW PROVIDERS GRASPING FOR A POSITION WITHIN THE PROVIDER COMMUNITY. IT IS NO WONDER OLDER PERSONS AND THEIR CARE GIVERS FIND OUR ENTIRE HEALTH AND COMMUNITY CARE SYSTEM A CONFUSING MAZE TO WORK THROUGH; THE GROWTH OF COMMUNITY-WIDE CARE MANAGEMENT SYSTEMS HAS BEEN VERY IMPORTANT TO THE ELDERLY IN THESE CONFUSING TIMES.

BECAUSE OF EXTENSIVE SUCCESSFUL EFFORTS BY MANY AREA AGENCIES TO ADDRESS THE GROWING NEEDS OF THE ELDERLY POPULATION WITHIN THEIR COMMUNITIES, WE CONTINUE TO OPPOSE ANY PROPOSAL WHICH WOULD UNDERMINE THE EXISTING NETWORK ON AGING. TWO SUCH PROPOSALS ARE IN THE ADMINISTRATION'S BILL; ONE WOULD ALLOW STATES TO ABOLISH EXISTING AREA AGENCIES ON AGING AND ASSUME THEIR RESPONSIBILITIES AND ANOTHER PROVISION WOULD ALLOW DEMONSTRATION WAIVERS OF CRITICAL SECTIONS OF THE ACT. THESE PROVISIONS DO NOT PROVIDE FOR PLANNING AND DECISION MAKING AT THE LOCAL COMMUNITY LEVELS, THEY DIFFUSE RESPONSIBILITY AND WEAKEN ADVOCACY FOR OLDER ADULTS AT THE LOCAL LEVEL. IN ORDER TO IMPLEMENT THE CONGRESSIONAL INTENT OF THIS ACT TO ASSURE THAT OLDER AMERICAN ACT FUNDS ARE APPROPRIATED LOCALLY TO THE MOST NEEDY, WE CONTINUE TO SUPPORT LOCAL PRIORITY SETTING WHICH IS DETERMINED BY A LOCAL NEEDS ASSESSMENT AND PUBLIC HEARING PROCESS. WE THEREFORE, ALSO OPPOSE RECOMMENDATIONS TO EARMARK SPECIFIC FUNDS OR FEDERALLY MANDATED PERCENTAGES OF FUNDS TO ANY ONE PROGRAM AREA.

LONG TERM CARE PLANNING AND CARE MANAGEMENT ARE NOT JUST HEALTH-RELATED ISSUES. THESE TERMS INCLUDE EACH AND EVERY SERVICE WHICH WE ARE PROVIDING IN ALLOWING OUR ELDERLY TO LIVE INDEPENDENTLY AND WITH PRIDE AND DIGNITY.

THE AGING NETWORK IS A PROVEN AND EXISTING NETWORK THAT COVERS THE ENTIRE COUNTRY. WE ARE THE LOGICAL ENTITY TO ASSUME AN EXPANDED ROLE IN CARE MANAGEMENT; IT REINFORCES THE ORIGINAL INTENT OF THE OLDER AMERICANS ACT, THAT IS, TO ASSIST OLDER PERSONS TO REMAIN IN THEIR COMMUNITIES AND HOMES. BUT TRADITIONAL SERVICES REMAIN CRITICAL TO ACHIEVING THIS GOAL. WE THEREFORE, ARE SEEKING YOUR SUPPORT TO ASSURE THE INTEGRITY OF THE CURRENT TITLE III-B PROGRAMS AND TO ASSIST US IN FINDING NEW OR TRANSFERRED FUNDS, WHETHER THEY ARE FROM MEDICARE, MEDICAID, OR PUBLIC HEALTH TO SUCCESSFULLY FULFILL THESE ROLES.

WE PLEDGE OUR CONTINUED DEDICATION TO BE THOSE AGENCIES WHICH CAN BEST ASSIST OUR ELDERLY IN GAINING ACCESS, INFORMATION AND RESOURCES TO ALLOW THEM TO ENHANCE THE LIFE STYLES WHICH THEY SO RIGHTFULLY DESERVE. WE THANK YOU FOR YOUR CONTINUED SUPPORT TOWARD THESE ENDEAVORS.

IN CLOSING MAY I SHARE WITH YOU AN UNSOLICITED RESOLUTION BY OUR KAUAI COUNTY COUNCIL COMMENDING YOU AS MEMBERS OF THIS COMMITTEE AND SENATOR MATSUNAGA FOR SUPPORTING OUR LOCAL ELDERLY PROGRAMS ON KAUAI. [ATTACHMENT C] MAHALO NUI LOA [THANK YOU VERY MUCH]

7

ATTACHMENT A

EOA DRAFT

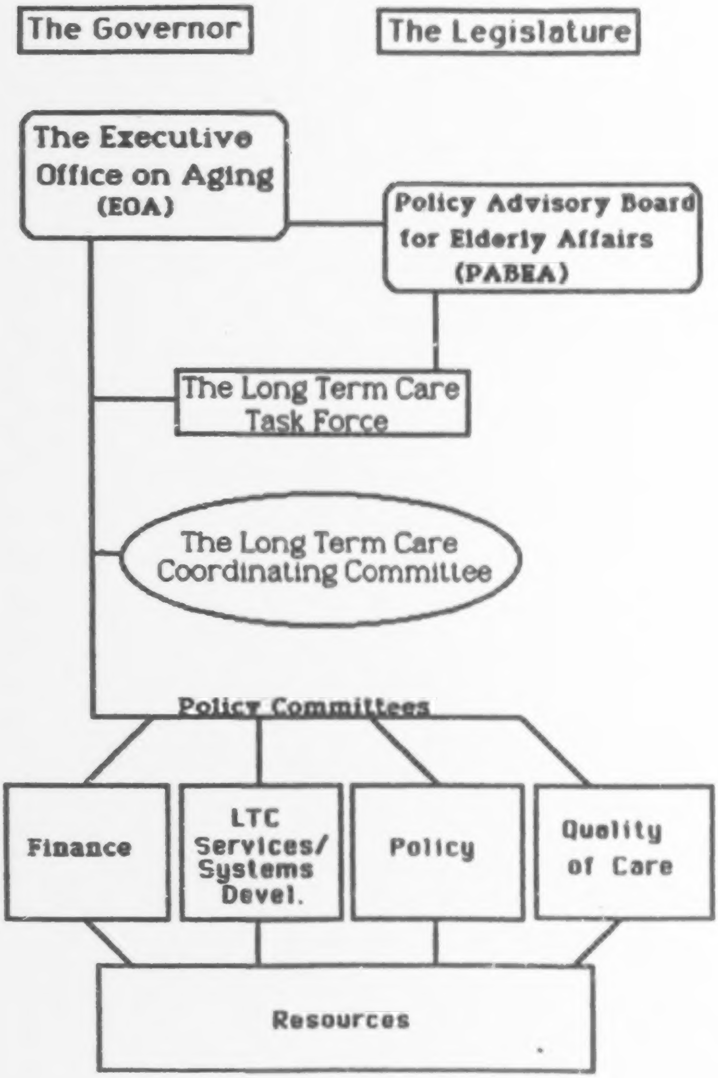
SERVICES AND ACTIVITIES PROVIDED BY THE AAAS

March 1987

SERVICES	KAUAI	HAWAII	MAUI	OAHU
ADULT DAY CARE	*	*	*	
ADULT EDUCATION	*	*	*	*
ALZHEIMER ~~SERVICE~~ Support	*	*	*	
CASE MANAGEMENT	*	*	*	*
CHORE SERVICES	*	*	*	*
COMMUNITY SERVICE DEVELOPMENT	*			
EMPLOYMENT SERVICES		*		
ESCORT	*	*	*	*
FRIENDLY VISITING	*	*	*	*
HEALTH MAINTENANCE	*		*	*
HEALTH PROMOTION	*			*
HOUSING ASSISTANCE				*
HOSPICE		*		
INFORMATION & REFERRAL	*	*	*	*
DISCOUNT I.D./BUS PASS	*	*		*
LEGAL ASSISTANCE	*	*	*	*
GUARDIANSHIP		*		
MULTIPURPOSE SENIOR CENTER	*	*	*	*
NUTRITION:	*	*	*	*
CONGREGATE MEAL SERVICES				
HOME-DELIVERED MEALS				
NUTRITION EDUCATION				
OUTREACH	*	*	*	*
PERSONAL ASSISTANCE ACTIVITIES	*	*	*	*
COUNSELING SERVICES				
FINANCIAL MANAGEMENT				
INTERPRETING/TRANSLATING				
LETTER WRITING/READING				
SHOPPING				
PERSONAL CARE		*	*	*
PROFESSIONAL COUNSELING				*
RECREATION/LEISURE	*	*	*	*
RESPITE	*	*		
RESIDENTIAL RENOVATION		*		
SMALL GROUP HOMES		*	*	*
TELEPHONE REASSURANCE	*			*
TRANSPORTATION	*	*	*	*
VOLUNTEER SERVICES	*	*	*	*

ATTACHMENT B HAWAii

ORGANIZATION CHART
Long Term Care Planning
Executive Office on Aging


The Governor
The Legislature
The Executive Office on Aging (EOA)
Policy Advisory Board for Elderly Affairs (PABEA)
The Long Term Care Task Force
The Long Term Care Coordinating Committee
Policy Committees
Finance
LTC Services/ Systems Devel.
Policy
Quality of Care
Resources

COUNTY COUNCIL
COUNTY OF KAUAI
Resolution
No. 29

RESOLUTION SUPPORTING THE REAUTHORIZATION OF THE OLDER AMERICANS ACT OF 1965

WHEREAS, federal legislation has been introduced to reauthorize the Older Americans Act of 1965, which provides a broad array of services and nutrition programs for older persons and which funds 57 state agencies and over 660 area agencies on aging, including Kauai's own Office of Elderly Affairs; and

WHEREAS, the organization and delivery of services to older Americans is facilitated primarily through the Older Americans Act; and

WHEREAS, in about 20 years Hawaii expects a 90 percent increase in the number of its residents over age 65, while the State's overall population will only increase by 30 percent at the same time; and

WHEREAS, this "aging" of our State strongly underscores the need for continuing and expanding those services to our elderly which are provided and funded through the Older Americans Act; and

WHEREAS, more than one third of Kauai's Office of Elderly Affairs entire annual budget is funded by the Older Americans Act, in order to provide: health screening, education and counseling; a senior "wellness" program, a nutrition program (congregate and home delivery meals); information and referral services; retirement and income counseling; transportation and escort services; leisure/educational activities; legal assistance; an Alzheimers-Respite Center and memory disorder support program; care management; and other programs and services to assist the elderly to live independently with dignity; and

WHEREAS, more than 4,000 older members of Kauai's island community out of a projected elderly population (60 years and over) of 7,000, benefit from these essential services or participates in the various programs; and

WHEREAS, in a state with the nation's best average longevity span, Kauai will continue to need federal assistance and support in its efforts to properly service the older members of our community, especially our frail and vulnerable elderly; now, therefore,

BE IT RESOLVED BY THE COUNTY OF KAUAI, STATE OF HAWAII, that it strongly supports the reauthorization of the Older Americans Act of 1965, which directly provides a very substantial portion of the funding for local elderly programs on Kauai.

BE IT FURTHER RESOLVED, that the Council extends a warm "mahalo" to Senator Spark Matsunaga for introducing legislation reauthorizing programs to aid Older Americans throughout our country.

BE IT FURTHER RESOLVED, that a copy of this resolution be forwarded to The Chairman (Senator Spark Matsunaga) and Members of the Subcommittee on Aging of the U.S. Senate's Labor and Human Resources Committee as a means of relaying the Council's position on the proposed legislation for upcoming hearings by the subcommittee at the end of April 1987.

BE IT FURTHER RESOLVED, that a copy of this resolution also be forwarded to U.S. Senator Daniel Inouye, U.S. House Representatives Daniel Akaka and Patricia Saiki, State Executive Office on Aging, Mayor Tony Kunimura, and Governor John Waihee.

INTRODUCED BY: Maxine Correa

CERTIFICATE OF ADOPTION

	Aye	No	A/E
Asing	X		
Correa	X		
Fukushima	X		
Kouchi	X		
Munechika	X		
Tehada	X		
Yukimura			X
	6	0	1

We hereby certify that Resolution No. 29 was adopted by the Council of the County of Kauai, Lihue, Kauai, Hawaii, on April 21, 1987.

Jerome Y. K. Hew
County Clerk

Chairman & Presiding Officer

Dated 4/21/87.

Senator MATSUNAGA. Thank you very much, Ellie.

We would be happy to hear from you now, Ms. Ferguson.

Ms. FERGUSON. Thank you, Mr. Chairman. My name is Wilda Ferguson and I am Commissioner of the Virginia Department for the Aging and President of the National Association of State Units on Aging.

I am pleased to present the viewpoints of the Association on reauthorization of the Older Americans Act. In my oral testimony I will briefly highlight several issues and request that our full position statement on reauthorization be included in the hearing record.

Senator MATSUNAGA. Without objection, it is so ordered.

Ms. FERGUSON. As State administrators of the Older Americans Act, we view ourselves as having two major responsibilities. First, through our position in State government, we seek policy and program advances which will help other public and private service systems to better respond to the needs of older persons.

We seek to accomplish these responsibilities by working with the governors, governors' advisory boards, State legislatures, other agencies in State government, the aging network, and organizations of older people.

Secondly, we develop the policies and State-wide structures for administering the Act at the local level. Through our partnership with area agencies on aging, the program funds authorized under this Act are used to support those services most needed in our communities.

In both our policy change role and service development role, we are part of a larger State human service system. In this town, too often, it seems, the Older Americans Act is seen in a vacuum as a freestanding program totally separate from services funded by the social services block grant, alcohol, drug abuse and mental health block grant, Medicaid home and community-based services, Medicare, State supplements to SSI, and other programs established and supported through State revenues or private funding.

By contrast, in our States the Older Americans Act is one component of the human services system greatly influenced by these other larger programs which we, in turn, seek to influence on behalf of older persons.

In order to best meet the needs of older people, we must make sure that the services funded under the Older Americans Act are provided in a way that complements these other programs. This reality provides a framework for the Association's reauthorization position.

We reaffirm our opposition to any federal requirement to spend a specific amount of Title III–B funds on any single service category. If we are to be responsive to the diverse needs of older people around this country, then we must be able to reflect differences in services and funding availability from State to State and community to community.

The vast differences among State human service systems also shape our viewpoint on how to best target services to those older persons most in need. Over the past decade, we have become increasingly frustrated by Older Americans Act policies which we believe to be unnecessarily restrictive and contradictory.

While we are to target services to the most disadvantaged, we are directed to achieve this objective without considering the income of persons. Our statement calls for Congress to clarify the objectives of the law regarding targeting and to give States the policy tools which we need to create a more rational role for the Older Americans Act in the context of larger human service systems.

We ask you to reaffirm that the Act is intended to develop effective programs and opportunities for all older Americans, regardless of income, ethnic origin, or disabling condition. This mission should continue to guide the activities of the organizations which comprise the aging network so that older persons continue to be viewed not as clients or dependents, but as participants, volunteers, planners, leaders and advisors in the development of responsive public and private programs.

However, we believe that the Act should authorize demonstrations which would allow selected States to test the effect of sliding fee scales for certain services. Due to the great diversity in State human service systems, we believe that such demonstrations should be conducted in a variety of States where the conclusions of a comprehensive evaluation can be logically applied to other States.

Such an evaluation should examine the effect of a sliding fee scales on four aspects of service delivery systems: one, the effect on targeting the program's resources on low-income and minority older persons; two, the effect on the equitable treatment of older persons with similar circumstances living in the same State and receiving services under various programs; three, coordination of the service delivery system; and, finally, the expansion of services available for low-income persons financed through fees generated under cost-sharing.

Our policy statement cautions that mandatory cost-sharing options should not be permitted for certain advocacy and access services such as information referral, outreach, ombudsmen, protective services, legal services, and case management. Advocacy and access services of the aging network are often the only means older persons have of learning about programs and benefits.

These three elements would contribute to the ability of States and area agencies to target service funds.

Finally, we request that an additional title be established in the Older Americans Act for the ombudsman program which would grant ombudsmen limited immunity from civil suits, would ensure ombudsmen access to patients in hospitals, and would provide protection for the ombudsman program from the impact of OMB Circular A-122.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Ferguson and a joint statement of the National Assistance of Area and State Agencies on Aging follow:]

NATIONAL
ASSOCIATION
OF STATE UNITS
ON AGING

600 Maryland Avenue, SW
Suite 208
Washington, DC 20024
(202) 484-7182

NASUA

Statement of

The National Association of State Units on Aging

on

Reauthorization of the Older Americans Act

Presented to

Senate Labor and Human Resources Committee

Subcommittee on Aging

By

Wilda Ferguson

Commissioner, Virginia Department on Aging
and
President, National Association of State Units on Aging

APRIL 30, 1987

STATES UNITED FOR ACTION IN AGING

Mr. Chairman and distinguished members of the Subcommittee on Aging. I am Wilda Ferguson, Commissioner of the Virginia Department on Aging and President of the National Association of State Units on Aging. I am pleased to present the view points of the Association on Reauthorization of the Older Americans Act. In my oral testimony I will only briefly highlight several issues and I request that our full position statement on reauthorization be included in the hearing record.

The Older Americans Act holds out the promise that all citizens of this country may look forward to aging with dignity, self-sufficiently as fully participating members of society. Recent reauthorizations of this Act have reinforced the view that the act is addressing itself to all older persons, regardless of income, ethnic origins or disabling conditions. The Act has also repeatedly strengthened the capacity of state governments and the aging networks they supervise to stimulate services systems and community organizations which are accessible, affordable and responsive to the needs and preferences of older people.

As state administrators of this Act, we view ourselves as having two major responsibilities. First, through our position in state government, we seek policy and program advances which will help other public and private service systems to better respond to the needs of older people. We seek to accomplish these responsibilities by working with the Governor, state legislature, other agencies in state government, the aging network, and organizations of older people.

Secondly, we develop the policies and statewide structures for administering the Act at the local level. Through our partnership with area agencies on aging, the program funds authorized under this Act are used to support those services most needed in our communities.

In both our policy change role and services development role we are part of a larger state human services system. In Washington D.C., too often the Older Americans Act is seen in a vacuum - as a free-standing program totally separate from services funded by the Social Services Block Grant, Alcohol, Drug Abuse and Mental Health Block Grant, Medicaid Home and Community Based Services, Medicare, state supplements to SSI and other programs established and supported through state revenues or private financing. By contrast, in our states the Older Americans Act is one component of a human services systems, greatly influenced by these other larger programs which we in turn seek to influence on behalf of older persons. In order to best meet the needs of older people, we must make sure that the services funded under the Older Americans Act are provided in a way that compliments these other programs. This reality provides the framework for the Association's reauthorization position.

We reaffirm our opposition to any federal requirements to spend a specific amount of Title III-B funds on any single service category. If we are to be responsive to the diverse needs of older people across this country, then we must be able to reflect differences in service and funding availability from state to state and from community to community.

The vast differences among state human services systems also shape our viewpoint on how to best target services to those older persons most in need. Over the past decade we have become increasingly frustrated by Older Americans Act policies which we believe to be unnecessarily restrictive and contradictory. While we are to target services to the most disadvantaged, we are directed to achieve this objective without considering the incomes of potential service recipients. Our statement calls for Congress to clarify the objectives of the law regarding targeting, and to give states the policy tools which we need to create a more rational role for the Older Americans Act in the context of larger human services systems.

We ask you to reaffirm that the Act is intended to develop effective programs and opportunities for all Older Americans, regardless of income, ethnic origin or disability condition. This mission should continue to guide the activities of the organizations which comprise the aging network, so that older persons continue to be viewed not as clients or dependents but as participants, volunteers, planners, leaders, and advisors in the development of responsive public and private programs in which any older person can participate with dignity and without social stigma.

However, we believe that the Act should authorize demonstrations which would allow selected states to test the effects of sliding fee scales for certain services. Due to the great diversity in state human services systems, we believe that such demonstrations should be conducted in a variety of states where the conclusions of a comprehensive evaluation can be logically applied to other states.

Such evolutions should examine the effects of a sliding fee scale on four aspects of service delivery systems.

1) The effects on targeting the program's resources on low income and minority older persons. Sliding fee scales are the primary tools used to target the resources of state funded programs - many of which exceed the level of support provided by the Older Americans Act. Below a certain income level, such as 150 percent of poverty, services for older persons would be fully subsidized by the Act. In addition, we believe that below this threshold, states should be prohibited from even requesting voluntary contributions for services which are part of a cost sharing demonstration.

2) The effects on the equitable treatment of older people with similar circumstances living in the same state and receiving services under various programs. Currently, older persons in one community may be making a co-payment for a service funded under Medicaid or Social Service Block Grant, while elsewhere in the same state the service maybe free because it is funded through Title III. It is difficult to establish equity in a state human service system when multiple funding sources are employed to create service delivery systems.

3) Coordination of the service delivery system. Such demonstrations can test whether cost sharing policies can enhance linkages among other federal state and federal programs. For example, states might

establish a "continuum" of sliding fee policies so that when an income threshold has been reached in one program, cost sharing under another program can begin. This will help address the problem of older people "falling through the cracks" of individual program criteria.

4) Expansion of service availability for low income persons financed through fees generated under cost sharing. States should be required to assure that all fees will be used solely to expand outreach and service delivery to low income and minority older persons.

Our policy statement cautions that mandatory cost-sharing options should not be permitted for certain advocacy and access services such as information and referral, outreach, ombudsman, protective services, legal services and case management. Advocacy and access services of the aging network are often the only means older persons have of learning about programs and benefits, and getting the necessary advice and assistance to negotiate the maze of public and private benefit programs.

These three elements would contribute to the ability of states and area agencies to target service funds to persons in greatest need, while maintaining our role to establish systems and organizations which are responsive to all older Americans.

Finally, as a reflection of NASUA's concern for quality care provided both in an individual's own home and in nursing homes, we propose the establishment of a new sub-title of Title III with two separate components. The first part would include legislative authority for the state long term care ombudsman programs and provide for a separate appropriation. Provision which we feel should be added to the current legislative language include:

- Granting ombudsmen limited immunity from civil suits for good faith performance of their duties;
- Ensuring ombudsmen access to patients in hospitals who have been transferred to hospitals from nursing homes; and
- Protecting the ombudsman program from the impact of OMB Circular A-122.

We propose that a second part of this new sub-title provide an authorization of funds for state units and area agencies to develop state - specific quality assurance initiatives on behalf of elderly persons receiving in-home services in which public funds are involved. We seek sufficient flexibility in this authorization to enable us to participate in quality assurance efforts in any publicly-funded community based long term care program, as determined by our Governors.

Mr. Chairman, in consideration of the Committee's limited time, I have discussed only a few of our policy positions. Thank you for the opportunity to share our views. I would be happy to respond to any questions of the Committee.

THE 1987 REAUTHORIZATION OF OLDER AMERICANS ACT

A Joint Statement

of the

National Association of Area Agencies on Aging

and the

National Association of State Units on Aging

Washington, D.C.

Positions Adopted by the NAAAA and NASUA Membership
August, 1986

600 Maryland Avenue, S.W., Suite 208, Washington, D.C. 20024

PREAMBLE

The Older Americans Act as originally written and amended is structurally sound. It has created an advocacy and service network that addresses the needs of older persons through a community system of monitored, quality care. At this time the Act does not need major structural changes. The following are "fine-tuning" recommendations for change. Items underlined are new additions recommended for insertion into existing statute, and items within parentheses are existing language of statute recommended for deletion.

1. REAUTHORIZATION PERIOD

It is recommended that the Older Americans Act be reauthorized for a period of three years, or through September 30, 1990. Concerning the time period for State and Area plans - it is recommended that the current language in Section 307(a) be retained: ...each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Commissioner a State plan for a two-, three-, or four-year period.

2. TITLE I

The following changes in Title I are to emphasize that the Older Americans Act advocates in behalf of: all aging persons, a broader perspective than just those over 60 years of age; and older persons as a group, not just for individuals. We also wish to: emphasize that older persons contribute to society as well as earn rights from it; address the current intergenerational issues by encouraging participation with other age groups; call attention to the need for protection against abuse; and recognize the important role of care givers of the elderly.

There are currently ten subsections in Section 101 of Title I. The proposed changes add new language to subsection 2,3,7 and 10. In addition, a new subsection 11 is added.

Section 101(2) The best possible physical and mental health which science can make available and at costs which older citizens can afford. (without regard to economic status.)

Section 101(3) To be able to obtain and maintain suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.

Section 101(7) Participate and contribute in (Pursuit of) meaningful activity within the widest range of civic, cultural, education and training and recreational opportunities with their peers and citizens of other generations

Section 101(10) Freedom, independence and the free exercise of individual initiative in planning and managing their own lives; protection against abuse, neglect and exploitation; and full participation...

(new) Section 101(11) Support to family members and others providing voluntary care to those older citizens needing long term care services.

3. TITLE II - PLACEMENT OF AOA

An Assistant Secretary for Aging should be established within the Department of Health and Human Services with responsibility for representing the interests of all older Americans within DHHS and with other federal departments and agencies, and for administering the Older Americans Act program.

If the Act is not changed to provide for an Assistant Secretary for Aging the following is proposed for the Office of the Commissioner on Aging.

Section 201(a)...there shall be a direct reporting relationship between the Commissioner and the (Office of the) Secretary. In the performance of the functions of the Administration, the Commissioner shall be directly responsible to the (Office of the) Secretary.

Section 202(a)(8) gather statistics in the field of aging, through the National Data Base on Aging sponsored by NAAAA and NASUA, which other Federal agencies are not collecting...

Section 207(a) not later than one hundred and twenty days after the close of each fiscal year, the Commissioner shall prepare and submit to the President and to the Congress a full and complete report on the activities carried out under this Act. Such annual reports shall include statistical data reflecting services and activities provided individuals during the preceding fiscal year. In addition, the Commissioner shall prepare and submit a plan of action for the new fiscal year, in consultation with State Units on Aging and Area Agencies on Aging, outlining specific goals and objectives to be met to implement the purposes of this Act.

4. AUTHORIZATION OF APPROPRIATIONS

The figures proposed here represent a 5% increase in authorized funding levels for Title III, for each of the three fiscal years.

Section 303(a) There are authorized to be appropriated $379,575,000 for fiscal year 1988, $398,554,000 for fiscal year 1989, and $418,482,000 for fiscal year 1990 for the purpose of making grants under part B...

b(1) these are authorized to be appropriated $414,750,000 for fiscal year 1988, 435,488,000 for fiscal year 1989, and $457,262,000 for fiscal year 1990 for the purpose of making grants under subpart 1 of part C...

(2) these are authorized to be appropriated $79,380,000 for fiscal year 1988, $83,349,000 for fiscal year 1989, and $87,516,000 for fiscal year 1990 for the purpose of making grants under subpart 2 of part C...

5. SINGLE ORGANIZATIONAL UNIT

This proposed language supports a single organizational unit functioning as the Area Agency on Aging. This does not prohibit the placement of an Area Agency on Aging within an umbrella agency, such as a council of governments, a regional planning district, city or county governments. It does however strengthen the Area Agency by assuring that it is a separate, identifiable unit within such an umbrella agency, assuring access to services and advocacy for older persons needing assistance.

Section 305(c)(2) any office or agency of a unit of general purpose local government, which is a single organizational unit designated for the purpose of serving as an area agency by the chief elected official of such unit.

Section 305(c)(3) any office or agency which is a single organizational unit designated by the appropriate chief elected officials of any combination of units of general purpose local government to act on behalf of such combination for such purpose.

Section 305(c)(4) any public or nonprofit private agency in a planning and service area, or single organizational unit within it, which is under the supervision or direction for this purpose of the designated State agency and which can engage in the planning or provision of a broad range of supportive services, or nutrition services within such planning and service area.

6. DESIGNATION

The intent of both organizations is to require State Agencies on Aging to hold a public hearing in the event of a change in the designation of planning and service boundaries. Below is language that attempts to strengthen the assurance that a newly designated area agency will be fully qualified to fulfill its mandates.

Section 305(c) an area agency on aging designated under subsection (a) shall be—[subsections 1 through 5 as amended above].....
and shall provide assurance, determined adequate by the State agency through an on-site assessment, that the area agency will have the ability to develop an area plan....

7. COST SHARING

The climate appears to be right for greater attention to cost sharing by participants for the services being provided to them. The intent of the changes here are to require that voluntary contributions be sought for III-B and III-C, and to allow States and Area Agencies to develop cost sharing for selected services.

To accomplish this a new subsection (L) is added to Section 306(a)(6). The language in this new paragraph is adapted from the wording in Section 307(a)(13)(C) which permits the solicitation of voluntary contributions for the nutrition program. A new subsection (F) is added to 305(a)(2) to provide for cost sharing.

In addition - Section 307(a)(17)(C) is amended to say that projects will solicit voluntary contributions.

Section 305(a)(2) the State agency designated under clause (1) shall—

(New) Section 305(a)(2)(F) be permitted to establish procedures for either voluntary or mandatory cost sharing for selected services on an ability to pay basis. Such mandatory cost sharing shall not be applied to limit such services as information and referral, outreach, and advocacy services, including ombudsman and protective services, which must be available to all persons 60 or over.

Section 306(a)(6) provide that the Area Agency on Aging will

(New) Section 306(a)(6)(L) solicit voluntary contributions for services furnished in accordance with guidelines established by the commissioner.

taking into consideration the income ranges of individuals in local communities and requirements imposed by other sources of funds of the recipient of a grant or contract, and such voluntary contributions will be used to maintain or increase services of the program...[consistent with 307(a)(13)(c)]

Section 307(a)(13)(C)(i)...each project will (permit recipients of grants or contracts to) solicit voluntary contributions... State agencies shall assure that cost-sharing plans do not inhibit giving priority to persons in greatest social and economic need.

8. TARGETING

The Associations support the existing language within 305(a)(2)(E) providing the assurance that "older individuals with the greatest economic or social needs, with particular attention to low income minority individuals", will be given preference for services. We also wish to target limited resources to the frail elderly through case management services and the utilization of functional assessments through the following addition:

Section 306(a)(6)(I) conduct efforts to facilitate the coordination of community-based, long term care services designed to retain individuals in their homes, thereby deferring unnecessary or inappropriate, costly institutionalization, and designed to emphasize the development of client centered case management systems through the utilization of functional assessments to determine need for services.

9. ADVOCACY

The following changes represent "fine tuning" on the matter of State and Area Agency advocacy efforts. Language is taken from OAA regulations to accomplish this. The changes accomplish: an emphasis on the fact that the

Act is for all older persons; State and Area Agencies have the right to comment on appropriate State and Federal matters affecting their constituents, but not necessarily required to comment on all such matters (as they may not have the capacity to do so). Periodic public hearings by State and Area Agencies are called for.

Section 305(a)(1)(D) serve as an effective and visible advocate representing the interests of older Americans (for the elderly) by reviewing and commenting upon (all) State and Federal plans, budgets, and policies which affect the elderly...

Section 306(a)(6)(A) conduct periodic evaluations (of) and public hearings on activities carried out under the area plan.

Section 306(a)(6)(D) serve as the advocate and focal point for the elderly within the community by monitoring, evaluating, and commenting upon (all) policies, programs, hearings, levies, and (community) actions which will affect the elderly regardless of any prohibitions of OMB A-122.

Section 307(a)(8) provide that the State agency will conduct periodic evaluations (of) and public hearings on activities and projects carried out under the State plan.

10. NUTRITION

The purpose of the following change is to allow the use of nutrition funds for services that may be needed but not clearly allowable for nutrition program participants.

Section 331(3)...which may include nutrition education services and other appropriate (nutrition) services (for older individuals) to meet the special needs of target groups [e.g. frail, minority, limited English-speaking, or disabled persons] among the participants, as established by State Title III policy.

11. COMMODITIES

The authorization of appropriations for the USDA Commodity Distribution program is increased by 10% over the next three years.

Section 311(4)...level of assistance of not less than 59.60 cents per meal during fiscal year 1988 and 1989, and 62.60 cents for fiscal year 1990.

Section 311(e)(1)(A)...there are authorized to be appropriated $151.2 million for fiscal year 1988, and 1989, and $158.76 million for fiscal year 1990 to carry out...

12. QUALITY ASSURANCE

The Long Term Care Ombudsman program should be a separate subsection of Title III with a separate authorization of appropriations. References to the ombudsman program found in Sections 304, 307 and 321 should be incorporated into the new subsection.

As a result of the growing elderly population living longer and healthier, and as a result of changes in the Medicare system returning patients to their homes for care, more older people are receiving in-home care services than ever. At the same time this trend is occurring, the federal government has reduced its regulatory responsibilities for in-home and institutional care and the public and Congress are calling for accountability, assuring that older persons are indeed receiving the quality services they need.

The aging network administering the OAA, currently is responsible for the monitoring of in-home services which it funds, as well as monitoring the care of elderly persons living in institutions. It is therefore reasonable to extend these oversight responsibilities on behalf of all elderly receiving publicly funded home care.

A new subsection, incorporating the strengthened ombudsman program, and the responsibility for in-home services monitoring by the State and Area Agencies is proposed as follows:

Title III

PART D - STATE AND AREA AGENCY ON AGING QUALITY ASSURANCE PROGRAM.

Subpart 1 - Long Term Care Ombudsman Program.

The following provisions should be included in the statutory language (307(a)(12) regarding assurances that the state agency will establish and operate...a long term care ombudsman program:

- o Ombudsmen should be granted limited immunity from civil suits for good faith performance of their duties.
- o Ensure ombudsmen access to patients in hospitals who have been transferred to hospitals from nursing homes.
- o Provide language which protects the ombudsman program from the impact of OMB Circular A-122.

  Also - In order to emphasize the role of the State Unit on Aging in the ombudsmen program - the following is proposed:
- o Section 307(a)(12) - provide assurances that the State Agency [State Unit on Aging] will...

The inclusion of the word agency puts the responsibility for the ombudsman program with the State agency (state unit on aging) designated to administer the Older Americans Act.

Subpart 2 - Home and Community Care Quality Assurance Program.

This subsection should provide statutory language for the State and Area Agencies to develop a quality assurance program for elderly persons receiving in-home services in which public funds are involved.

A separate authorization of appropriations should be provided for subsections 1 and 2 of new Part D.

13. LIABILITY

To address the growing concerns about liability issues the association will pursue statutory language similiar to that in legislation of the Health Systems Agencies. It is proposed:

> In general - Except as provided in subparagraph (B) - (I) an Area Agency on Aging shall not, by reason of the performance of any duty, function, or activity, required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if the member of the governing body, an advisory council of the agency or employee of the agency who acted on behalf of the agency in the performance of such duty, function, or activity acted within the scope of his duty, function, or activity as such a member or employee, exercised due care, and acted without malice toward any person affected by it; and (II) no individual member of the governing body or advisory council of an Area Agency on Aging or employee of an Area Agency on Aging shall, by reason of his performance on behalf of the agency of any duty, function, or activity required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision of a State) if he believed he was acting within the scope of this duty, function, or activity as such a member or employee, and with respect to such performance, acted without gross negligence or malice toward any person affected by it.

(B) Exception - Subparagraph (A) does not apply with respect to civil actions for bodily injury to individuals or physical damages to property brought against an Area Agency on Aging or any member of the governing body advisory council of or employee of such an agency.

14. TITLE IV

The language proposed here clearly identifies the role of the two associations in the establishment and operation of the National Data Base on Aging and sets forth certain priority areas for Title IV funds.

Section 420(2) establish an information base of data and practical experience with particular emphasis on the National Data Base on Aging established by the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

(New) (6) Provide technical assistance to State Units on Aging and Area Agencies on Aging in carrying out their responsibilities.

Section 422 (b)

(New) (9) Address the causes and remedies associated with neglect abuse and exploitation of the elderly.

(New) (10) Demonstrate quality assurance practices for long term care services.

(New) (11) Promote affordable long term care services.

15. TITLE V

The language proposed here is to require that the National Contractors cooperate with the State Units on Aging in developing a statewide plan for the allocation of job slots in each State. There is also a provision calling for cooperation between the National Contractors and the JTPA program at the State and local level.

In the absence of statutory language requiring a jointly produced State plan - it is recommended that the law should at least require that procedures be established and implemented that will assure coordination of all Title V slots in each State.

Section 502(d)(1)...whenever a national organization or other program sponsor conducts a project within a State such organization or program sponsor shall, participate with the State Unit on Aging in joint development of a statewide operational plan including equitable distribution of slots within the state for the Community Services Employment for Older Americans Program, for the approval of the Governor of the State. National contracting organizations shall cooperate at the state and local levels with the state Job Training Partnership Act program. (submit to the State agency on aging a description of such project to be conducted in the State, including, the location of the project, 30 days prior to undertaking the project, for review and comment according to guidelines the Secretary shall issue to assure efficient and effective coordination of programs under this title.)

16. TITLE VI

The position on Grants for Indian Tribes in the reauthorization is to continue to support direct funding to Indian tribes, and to call for an appropriation which is at a level adequate to serve the eligible constituency.

(New) Section 604(a) (10) Title VIII recipients will not be precluded from receiving Title III services.

17. INTERGENERATIONAL ACTIVITIES

In recognition of the growing dialogue on the subject of intergenerational matters it is proposed that there be language in the Act that acknowledges the contributions that the elderly are capable of making to children and youth - and to encourage intergenerational activities. The following change is proposed

Section 306(a)(6)(E)...where possible, enter into arrangements with organizations providing services to benefit children so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, especially those in poverty in alternate care or under protective services; and to encourage where possible other intergenerational activities.

Senator MATSUNAGA. Thank you very much, Ms. Ferguson.

We will be happy to hear from you now, Mr. Reilly.

Mr. REILLY. Mr. Chairman, I have submitted our full statement and will focus right now on three issues in Title III and one in Title V.

The primary focus of Title III has been on preventing dependency by combatting social isolation and loneliness, providing social services, and providing opportunities for older persons to remain active in their communities.

This focus is expanding to include services to the rapidly growing number of frail older persons in their communities. This change had begun prior to 1984, but the pace has been accelerated by the 1984 amendments, State concerns about rapidly rising Medicaid costs which lead to State targeting initiatives in Title III-B, and the general lack of program funds to serve the seriously impaired who are not residents of nursing homes.

The service needs of severely impaired older persons frequently require a mix of health care and social services. These services are very labor-intensive, which raises the cost, whether in group settings or in the home. When delivered in the home, the one-on-one nature of these services further raises the cost.

As the aging network moves into this area in a period of rare funding increases, several serious issues arise that could change the basic nature of the Older Americans Act in undesirable directions.

The first issue is a tendency toward medicalization of Title III. The increasing number of impaired older persons in our communities, their families and the Title III network are confronted by the lack of a national policy on long-term care.

The need for in-home and community-based long-term care services is growing rapidly. The natural growth resulting from the increased numbers of the old is being accelerated by the sicker and quicker hospital dischargers, resulting from the Medicare prospective payment system.

As the States search for more money to meet these needs, the Older Americans Act Title III funds are a tempting target because they are flexible and have low State and local matching requirements.

These pressures have resulted in an increasing number of State and area agency targeting initiatives which tend to restrict Title III-B services to the frail elderly. Some proposed amendments to the Act would move in the same direction.

We strongly disagree with this movement because it will incrementally turn Title III-B into a health care-oriented community long-term care adjunct to Medicare and Medicaid, with funding completely inadequate to the role.

We believe that the answer to the need for health-oriented community long-term care systems is to be found in proposals such as H.R. 65, which would provide an entitlement program for long-term care supported by a tax base. Senator Graham's proposals here today may be an interim step.

The Title III program has made a substantial investment in the development of service delivery systems providing congregate, preventive and supportive services in communities across the nation.

Senior centers and other agencies providing these preventive and supportive services should remain an integral part of the Title III continuum of services or we will weaken the service continuum at one end while attempting to strengthen it at the other end.

We believe that this reauthorization of the Act should make it clear that Title III funding for in-home services and adult day care should be limited to those services currently non-reimbursable through Medicare, that a balance should be maintained between preventive and maintenance services, and that a new funding source is needed for medically-oriented community long-term care.

The second issue is closely related; it is proposals to impose mandatory fee schedules. The flat funding in recent years while the size of the older population has been growing and the number of severely impaired persons in the communities has been increasing has generated proposals for authority to impose mandatory sliding scale fees for service.

The philosophy of the Older Americans Act from the beginning has been that no means test would be imposed, though voluntary contributions could be sought. The legislative history on this intent is strong and clear. The important principles should be retained.

The introduction of complex bureaucratic rules and procedures to set fees by income level would be a major step into means testing and a diversion of limited service dollars to administering these tests.

So-called declaration methods have a history of becoming involved later with proofs of income. Any fee schedule requires a poor older person to identify herself as unable to pay. It could further reduce participation by the poor.

We strongly oppose permitting mandatory sliding fee schedules in Older Americans Act programs.

The third issue is the designation of community focal points. We urge the Subcommittee to include report language directing the Commissioner on Aging to exert leadership toward implementation of Section 306, which provides for the designation of community focal points important for coordination of service delivery at the community level. This provision has been largely ignored.

The issue in Title V was already addressed with Mr. Jones. We recommend very strongly that the Committee eliminate the decline to 12 percent which is included in the Act at this point, retain the 13.5 percent, and set specific criteria for waivers for some of the smaller contractors and rural operators who may not be able to reach the 13.5 percent level.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Reilly follows:]

THE NATIONAL COUNCIL ON THE AGING, INC.
Since 1950 working to improve the lives of older Americans

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REAUTHORIZATION OF THE OLDER AMERICANS ACT

Testimony by

Donald F. Reilly
Senior Vice President
The National Council on the Aging, Inc.

Before

The Subcommittee on Aging
of the
Senate Committee on Labor and Human Resources

April 30, 1987

Chair Barbara Sklar, 1st Vice Chair Frankie M. Freeman, Esq.
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Mr. Chairman, the National Council on the Aging, Inc. is pleased to present our comments on, and recommendations for, the reauthorization of the Older Americans Act. My name is Donald F. Reilly. I am the NCOA Senior Vice President. Prior to joining NCOA in 1979, I was the Deputy Commissioner of the U. S. Administration on Aging for seven years. In that role, and in previous positions, I was involved in developing most of the provisions of the current Act, including the drafting of the sections which mandate the establishment of the area agencies on aging.

The National Council on the Aging includes as membership units, the National Institute of Senior Centers, National Institute on Adult Daycare, National Institute on Community-based Long-term Care, National Institute of Senior Housing, National Association of Older Worker Employment Services, National Voluntary Organizations for Independent Living for the Aging, and the National Center on Rural Aging. We represent a very broad coalition of organizations, agencies and individuals concerned about meeting the needs of older persons.

Overview -- Title III

The enactment of the Older Americans Act of 1965 was a timely response to the emerging needs of the first sizeable number of retired persons in our history and the growth in numbers of the older population. We knew little in 1965 about the life changes that accompany retirement from the work force. We knew less about the potential of this new group for volunteer service and community service employment. Social isolation was a newly discovered phenomenon. The frail elderly were not yet identified as a growing subgroup of the older population. But it was already clear that older persons, as a group, had significant needs for services and opportunities, and that this population and its needs, would continue to grow.

During the 22-year period since enactment, older persons have grown rapidly in total number. In 1965 there were 18.4 million persons over the age of 65, constituting 9.5% of the total population. The number increased to 28.6 million in 1985, 12% of the population. It is projected to rise to 39 million in the year 2010, 13.8%; and to 65 million in 2030, 21.2%, as the baby-boom generation becomes senior citizens. The age profile has also been changing as increasing numbers live into their 80's and 90's. The population age 80 and over was 1 million in 1965, 0.6% of the total population. It is projected to rise to 8.6 million, 2.5%, by 2030. This old-old group is more likely to have severe and multiple impairments, which put them at higher risk of needing in-home and community-based services and of having to enter a nursing home.

During this period, the Older Americans Act and the programs operated through its funding have continued to evolve. Originally, under Title III, state agencies on aging made seed money grants to senior centers and other community service agencies for the start-up and expansion of services. The Act was amended to have area agencies on aging designated by the state agencies. The role of each area agency is to provide leadership to all organizations which serve, or should serve, the needs of older persons, and to fund selected service providers toward development of a "comprehensive and coordinated service system to serve older individuals" within its multi-county, county or city planning and service area. The Act was subsequently further amended to have area agencies "designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multi-purpose senior centers as such focal point." Provisions for the development of long-term care ombudsmen and legal services were also added. The 1984 reauthorization added further area plan requirements: ". . . facilitate the coordination of community-based long-term care services designed to retain individuals in their homes . . . and designed to emphasize the development of client-centered case management as a component of such services; . . . work to ensure community awareness of and involvement in addressing the needs of residents of long-term care facilities; . . . and assess the unmet needs for services of abused, neglected and exploited older persons."

The periodic changes in Title III have responded to increasing information about the needs and problems of older persons identified by senior centers and other community-level Title III service providers, Title V Senior Community Service Employment programs, state and area advisory committees, public hearings on state and area plans, national aging organizations and Title IV research and demonstration projects. The consistent intent of these incremental amendments has been to increase the accessibility of services to older persons who need them, and to reduce fragmentation of services in order to assure that service delivery is coordinated to meet the specific needs of the individual older person.

A national network on aging has emerged to respond to this intent. It is made up of 57 state agencies on aging, 670 area agencies, over 10,000 senior centers, and approximately 8,500 other service provider agencies, augmented by approximately 87,000 volunteers, and national voluntary agencies. Its primary focus has been on preventing dependency by combatting social isolation and loneliness, providing social services, and providing opportunities for older persons to remain active in their communities. This focus is expanding to include services to the rapidly growing number of frail older persons in their communities. This change had begun prior to 1984, but the pace has been accelerated by the 1984 amendments, state concerns about rapidly rising Medicaid costs, which lead to state targeting initiatives by Title III, and a general lack of program funds to serve the seriously impaired who are not residents of nursing homes.

The service needs of severely impaired older persons frequently require a mix of health care and social services. These services are much more labor-intensive, which raises the cost, whether in group settings or in the home. When delivered in the home, the one-on-one nature of these services further raises the cost. As the network moves into this area in a period of rare funding increases, several serious issues arise that could change the basic nature of the Older Americans Act in undesirable directions.

The first problem that the increasing number of impaired older persons in our communities, their families, and the Title III network are confronted by is the lack of a national policy on long-term care. By default, Medicaid has become the major funder of institutional long-term care. It was not designed for that role. Neither Medicare nor Medicaid is designed to be a major funder of community long-term care, whether in-home or community-based congregate services. Thus, other than out-of-pocket costs by impaired older persons or their families, the services are paid for by an unstable combination of Medicaid, Medicaid waivers in states which have such waivers, the Title XX Social Services Block Grant, Title III of the Older Americans Act, and state and local funds. The combination varies from state to state, and community to community.

The need for in-home and community-based long-term care services is growing rapidly. The natural growth resulting from the increased numbers of the old-old is being accelerated by the "sicker-and-quicker" hospital discharges resulting from the Medicare prospective payment system. As the states search for more money to meet these needs, the Older Americans Act Title III-B funds are a tempting target because they are flexible and have low state and local matching requirements. These pressures have resulted in an increasing number of state and local targeting initiatives which tend to restrict Title III-B services to the frail elderly. Some proposed amendments to the Act would move in the same direction. We disagree with this movement because it will incrementally turn Title III-B into a health-care oriented community long-term care adjunct to Medicare and Medicaid, with funding completely inadequate to the role.

We believe that the answer to the need for a health-oriented community long-term care system is to be found in proposals such as H.R. 65, introduced by Congressman Pepper. It would create a Medicare Part C, funded by a tax, to pay for these necessary services. This approach would provide a guaranteed funding base, make community long-term care an entitlement for those who need it, and avoid means testing. If legislation of this type cannot be enacted this year, then we favor interim measures to generate substantial additional funds, such as liberalizing the current Medicare home health regulations and policies, and making the Medicaid Section 2176 waiver provisions available to all states.

The Title III program has made a substantial investment in the development of service delivery systems providing congregate preventive and supportive services in communities across the nation. Information and referral, counseling, health screening and education, legal and financial counseling, home repair, special transportation, congregate meals, group activities, support groups, and volunteer projects can help maintain independence and prevent or delay a future need by many older persons for in-home services, adult daycare, or institutional long-term care. Senior centers and other agencies providing these services should remain an integral part of the Title III continuum of services, or we will weaken the service continuum at one end while attempting to strengthen it at the other end. We also oppose any increase in the age range covered by the Older Americans Act, since it would be another move to reduce preventive services.

It is in the area of in-home services and congregate programs for the frail where social services and health services come together in blends which are still evolving. Adult daycare is a rapidly increasing service which provides social daycare for impaired older persons. Some agencies have specialized in providing daycare for older persons whose impairments require periodic health or health-related services. This type of service is usually called Day Health Care. Public policy has not yet clearly addressed the appropriate funding sources for each type, and the line of demarcation between them.

Some older persons confined to their homes can be maintained by home-delivered meals, friendly visiting, telephone reassurance, and chore services. Some also need homemaker services. Others also need home health aide services. Others need more intensive medical services. How Medicare, Medicaid, and Title III funding should come together in this area has also not been resolved.

The National Association of Area Agencies on Aging reports that their member agencies are already spending a disproportionate percentage of their funds on services for the frail home-bound person. We believe that this reauthorization of the Act should make it clear that Title III funding for in-home and adult daycare should be limited to those services currently non-reimbursable through Medicare, i.e., long-term assistance with personal care, homemaking, shopping; that a balance should be maintained between preventive and maintenance services; and that a new funding source is needed for medically-oriented community long-term care.

Another issue is related. The flat funding in recent years, while the size of the older population has been growing and the number of severely impaired persons in the communities has been increasing, has generated proposals for authority to impose mandatory sliding-scale fees for service. The philosophy of the Older Americans Act from the beginning has been that no means test would be imposed, though voluntary contributions could be sought. This important principle should be retained. The introduction of complex bureaucratic rules and procedures to set fees by income level would be a major step into means testing, and a diversion of limited service dollars to administering these tests.

A third issue is that the general cutbacks and capping of domestic programs have caused some groups who advocate for special populations to consider seeking special funding set-asides within the Older Americans Act. The system-building role of state and area agencies includes reaching out horizontally to other service systems, such as mental health, developmental disability, and the blind.

It also includes assuring that the needs of all older persons are considered in the development of area service plans. However, the Title III-B funding is too limited to make special set-asides a feasible pattern. This does not conform to the principle of local funding flexibility.

Overview -- Title V

The Senior Community Service Employment Program continues to be successful. NCOA is one of the national contractors who work with the Department of Labor to find low-income older persons who want to return to the work force, and place them in subsidized community service employment or unsubsidized employment. We operate through local agencies in 61 communities across the country, and directly operate a large Los Angeles project.

NCOA Title V operations provided employment opportunities for 9,762 older men and women during the last year. Unsubsidized employment placement was achieved for 1,513 participants, and subsidized community service employment was located for 8,249 low-income older workers. The work they do allows community service agencies to expand their services to persons who need them.

More than 80% of the participants were above 60 years of age. 84% had income below the poverty level. Almost 75% were older women. 44% had less than 12 years of education. 39.1% were minorities.

This program is threatened by a provision inserted in 1984, which reduced the administrative allowance for operating the program from 15% to 13-1/2%, on July 1, 1986, and which will reduce it to 12% as of July 1, 1987.

The reduction to 13-1/2% from 15% was a 10% cut. We eliminated staff positions, and the 61 local agencies who are our subgrantees squeezed on all components of their budgets. We have been told by many of these agencies that they will have to consider withdrawing from the program if the reduction to 12% takes place, because they have no additional local funds to draw upon. The most likely to withdraw are small agencies in the less populated areas. This would require us to consolidate projects for more economical operation, so that we could monitor them with less staff. This, in turn, would displace older persons from the program.

Meanwhile, the administrative allowance cap for the Job Training Partnership Act, the Department of Labor's largest employment program, remains at 15%. There is no logical basis for the lower rate for Title V.

The further reduction to 12% for Title V will be counterproductive as to program quality and effectiveness. We urge the Subcommittee to delete the provision for the further reduction, and to restore the cap to 15%, comparable to JTPA.

Another issue in SCSEP is the per-enrollee unit cost. The current level was set at $5,111 in 1981. It has not been adjusted since, dispite inflation and rising costs in areas such as Workers' Compensation, Social Security, and other administrative costs. We recommend that the per-enrollee unit cost upon which slot allocations are made be increased by the 1981-86 inflation increase.

Overview -- Title VI

It is clear that older Native Americans have special problems. The establishment of Title VI was a step forward, since it explicitly provided for grants for Indian Tribes. However, the proportion of minority persons served under Title III has declined. There are older Indians living in communities across the country who are not reached by the Tribes, or by area agencies under Title III. The low funding level of Title VI has limited the scope of services by the Tribes. Therefore, there is a need for a crossover provision. The Subcommittee should make clear that Indians who receive a service under Title VI should not be precluded from receiving other services under Title III. We also support a series of amendments which will be proposed by the National Indian Council on Aging.

OTHER RECOMMENDATIONS

Reauthorization Period

The programs under the act should be extended four years, through fiscal year 1991. A longer period than the usual three-year extension will help assure stability and a focus on mid-term as well as short-term planning. However, we believe that a five-year extension, bringing the next reauthorization well into the third year of a new Administration and two years beyond the next White House Conference, may be too long.

Appropriation Authorizations

The authorization of appropriations for fiscal year 1988 and subsequent years should be for specific amounts which reflect the continued rapid growth of the older population, and the fact that there is not one community in the nation that has a truly comprehensive and coordinated service system for older individuals. "Such sums" authorizations, as recommended by the Administration, are an invitation to appropriations reductions in this period of competition for resources. The Older Americans Act programs are not "mature" in the sense of having substantially achieved the legislative program goals. These programs are still evolving, and serving only a portion of the population which needs the services. We recommend at least a 20% increase for Titles III-B, III-C1 and III-C2, and Titles V and VI.

We also oppose including the Older Americans Act appropriations into a generic Office of Human Development appropriation, as proposed by the Administration.

RECOMMENDATIONS FOR TITLE III

Categories of Services

Section 306 sets forth the requirements for area plans. 306 (a) (1) states that each area plan shall "provide through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance or construction of multipurpose senior centers . . . ."

306 (a) (2) requires that each area plan shall "provide assurances that an adequate portion of the amount allocated for part B to the planning and service area will be expended for the delivery of each of the following categories of services:

(A) . . . access . . .;

(B) in home services . . .; and

(C) legal assistance . . . ."

The three categories of service were originally listed for this protection because of a concern that they were underfunded, since the great majority of funds were being committed to other community services. Many now interpret this provision as stating a priority for the three listed areas of service over other community services. This misconception should be rectified.

306 (a) (2) should be revised to become a logical corollary to 306 (a) (1). We recommend the following language:

(2) "provide that an appropriate proportion of the amount allotted for Part B to the planning and service area will be expended for each of the categories of services which constitute the framework of a comprehensive system:

(A) . . . access . . .;

(B) community services provided outside the home (whether individually or in group settings);

(C) in home services . . .;

(D) services provided to the institutionalized; and

(E) legal assistance . . . and advocacy."

This structure would eliminate the ambiguity inherent in the current provision by changing it into a description of the categories which make up a comprehensive system, which is not defined elsewhere in the act. It would make clear that the Congress does not down-rate the importance of preventive and supportive services delivered outside the home by multipurpose senior centers, daycare centers and other service providers. It would make clear that some outreach to the institutionalized elderly is an appropriate part of each community services plan. And it would make clear that the allocation of funds between these catgories would be done by the area agencies on the basis of local circumstances.

Program Coordination

Section 306 (a) (3) provides that area agency plans shall "designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers as such focal point." Some states and area agencies have implemented this provision, but most have not. Even where designations have been made, in most cases there has been little or no increase in resources awarded or authority conferred to implement the focal point functions. There has been no leadership by the Administration on Aging in this area.

A community focal point for service delivery should be the local partner of the area agency and state agency in each community. It should be a highly visible one-stop location for older persons and their families to get information on the services and opportunities available, provision of needed services on-site wherever feasible, referral to other appropriate service providers, and, coordination of services as necessary. This is not a feasible role for an area agency because their jurisdiction covers a multi-county, county or city area.

Without such designated community focal points, the further development of coordinated service delivery will be severely hampered. Even today in most communities, an older person or family member seeking assistance that involves multiple services is likely to run into major difficulties in identifying what services are available, who provides them, feasible alternatives, and how to integrate them into a supportive package. Access to needed services, and coordinated delivery tailored to individual needs are the functions that are central to the role of community focal points. The Subcommittee should make clear in its report that it expects AoA to exert leadership in achieving compliance with the full intent of the focal point provision.

Adult Day Care

Adult Day Care is a newly emerging service. It meets a critical need of working families for care of an impaired elderly parent or relative during the work week. This has become much more important with the large-scale movement of women into the work force. It also provides temporary respite for full-time caregivers. It is growing because the need is urgent, but the growth is restricted by lack of funding. This limits the access of lower and middle income families to an additional social support which may avert the need for more expensive in-home care or entrance into a nursing home.

Adult Day Care should be added to Section 321 (a), the list of optional services which can be supported under Title III, Part B, "Supportive Services and Senior Centers." It should be inserted as item (6), with the current items (6) through (19) being renumbered.

Also, we recommend that Section 307 (b) (13) be amended to make it clear that older persons and handicapped or disabled individuals who have not attained age 60, but who attend an adult daycare center, are eligible for participation in the congregate meals program at the day care site.

Senior Center Services Utilization Study

We support the proposal of Congressman Solarz to required a national "Assessment of Unsatisfied Demand for Supportive Services" provided at senior centers and other sites. Such a comprehensive national study is needed to measure better the scope of OAA-funded senior center services and the dimensions of unmet need. Such data will provide the Congress with the base line information on which more accurate projections of appropriations requirements can be made.

Senior Center Operation Costs

The use of Title III, Part B, funds for the purpose of assisting in the operation of multipurpose senior centers is authorized in 321 (b) (2). This location causes confusion because 321 (b) (1) deals with the acquisition, alteration, or renovation of existing facilities and the construction of new senior centers. We recommend that the present 321 (b) (2) be relocated as the last item in 321 (a), the list of eligible activities under "Supportive Services and Senior Centers."

Long-Term Care Ombudsmen

Section 207(a) (12) should be amended to extend the responsibility of long-term care ombudsmen to include in-home and community-based long-term care services as well as institutional facilities. The possibilities for abuse appear to be greater in the one-on-one home-care situation than in the supervised setting of a nursing home. Additional funds will be needed to carry out this important but difficult task, and we recommend that the Committee Report direct the Administration on Aging to fund demonstration projects to determine the most feasible techniques for carrying out this role.

New Title III, Part D

We recommend that the new Title III, Part D, included in H.R. 1451 be modified to include Adult Daycare, which provides similar supportive services in a congregate setting. This new part will be valuable because it provides a focus within Title III on the need for social care for frail older persons, and provides additional funds for the purpose.

RECOMMENDATIONS FOR TITLE IV

Program Standards

NCOA has recently developed, through our National Institute on Adult Daycare, the first national standards for development and operation of adult daycare centers. We previously developed, through our National Institute of Senior Centers, national standards for the development and operation of multipurpose senior centers. We are currently developing, through our National Institute on Community-based Long-term Care, national standards for case management.

The delivery of needed services is critically important. But it is equally important that the services be of high quality, and effectively delivered and managed. The introduction of standards for service delivery becomes increasingly important as the clientele becomes older and more frail. The NCOA Institutes are developing standards through committees of volunteers from community agencies, supported by our limited resources. The work on development and updating would be speeded up greatly by additional funding for the gathering of survey data and the support of committee workshops.

We recommend that the following language be added to Section 421 (c) (2): ". . . and develop standards to assure high quality services and effective delivery and management of such services."

We also recommend that the committee report direct AoA to provide support for the development and dissemination of standards, leadership to the states toward adoption of national program standards, and support for technical assistance in implementation.

Minority Participation

We recommend that the Committee Report direct that AoA seek proposals for an analysis of the current reporting systems and demonstration projects on how to increase minority participation in Title III service programs.

RECOMMENDATIONS ON TITLE V

Administrative Cost Limitation

The current provision which will reduce the administrative cost limit from 13-1/2% to 12% should be deleted. The reduction last year from 15% to 13-1/2% has already caused operational problems. A further reduction will cause some local community agencies to drop out of the program, forcing the movement of slots to consolidated projects in other communities. It will also require reductions in technical assistance, training and monitoring. The impact of the further reduction will be counterproductive to the job placement program.

We favor the waiver provisions introduced by Representative Kildee in his Substitute to H. R. 1451. Those waiver provisions will provide reasonable opportunities for all Title V program operators to demonstrate to the Secretary of Labor the need for additional administrative support in specific circumstances.

Enrollee Unit Cost

The enrollee unit cost should be increased to compensate for inflation.

Governor's Signature-on Plan

We oppose the proposed amendment which would require each Governor to sign a plan for equitable distribution of program slots within the state, including the slots of all national contractors, prior to the release of Title V funds each year. NCOA works closely with each state agency to jointly work toward further equitable geographic distribution within each state. We are aware of no problems with our relationships with any state. The proposed procedure appears to merely add another procedural layer to the program.

RECOMMENDATIONS FOR TITLE VI

The need for services for older native Americans is very large because of the prevalence of deep poverty. Further, the delivery of services to this population is especially difficult due to the geographic isolation of reservation homes. We recommend a 20% increase in the funding of Title VI to help address these problems. We also endorse the recommendations of amendments that will be made by the National Indian Council on Aging.

RECOMMENDATIONS FOR TITLE VII

The National Governors' Association has recommended an initiative on the promotion of wellness as a parallel to the initiative on in-home services. We agree that congregate programs of health screening, health education, and exercise can often prevent or delay physical impairment. Senior centers are becoming increasingly active as wellness centers. We recommend that the Subcommittee Report stress its strong support for funding of these services under Title III and Title VII utilizing senior centers as the prime delivery points for such congregate services.

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Thank you again for the opportunity to present our views. NCOA will be pleased to answer any questions about our comments or recommendations. We will also be pleased to work with the Subcommittee in any way that would be useful.

Senator MATSUNAGA. Thank you very much, Mr. Reilly.

Now, Ms. Dusenberry, some criticism has been lodged against the Administration on Aging for failing to maintain sufficient staff in order to provide the necessary services by cutting staff and also by detailing staff to other agencies.

What has been your observation in this regard?

Ms. DUSENBERRY. As a proponent of State and local government control—and I see us asking State and local governments to do more, and the private sector, also—I do not have a problem with that kind of delegation and reduction if the job is being done properly at the State and local level.

Senator MATSUNAGA. But in your prepared statement, did you not make a suggestion that the expanded programs would require closer federal supervision, or "oversight," I think, was the term you used?

Ms. DUSENBERRY. This was oversight in the ability of the Commissioner to deal directly with the Secretary and to be counseling directly and serving directly under the Secretary so that when decisions are made that are concerned with the Older Americans Act, the Commissioner is directly involved. That is what we were speaking of.

As an example, recently over half the appropriation for Title IV of $25 million was—diverted to other programs without the Commissioner even knowing that half of that appropriation was going to be diverted.

This is the kind of direct interplay that we feel the Commissioner needs to have, and that is the oversight that we were talking about.

Senator MATSUNAGA. I see, and you feel that it should be provided statutorily?

Ms. DUSENBERRY. Yes. The direct interplay between the Secretary and the Commissioner should be a part of the Older Americans Act.

Senator MATSUNAGA. Thank you very much.

Now, Ellie, as I understand it, the National Association of Area Agencies on Aging is proposing that area agencies be allowed to provide case management services directly without receiving a waiver from the State agency.

Do you anticipate that if area agencies were to continue to request permission of State agencies to provide case management directly that there may be difficulty in receiving such State approval, or have you had any experience in having denial of your requests from way out on Kauai?

Ms. LLOYD. Senator, we are presently, and have been for three years, providing case management services. I think we have a situation of semantics here in that some of use "case management." We are also using "care management."

We try on a local level to differentiate between those two terms. Many agencies, including State agencies, private agencies, and counseling agencies, will say that they do case management.

If you look at that, in essence, what they are doing is they are doing a vertical case management or case work. What we are trying to do is care management, or what we were calling case management, but we are now calling it care management, which gives a horizontal approach to that.

What we are trying to accomplish is to take that elderly person and to assist them in walking through the whole network of services which they need in order to help them to remain independent.

Now, if I may add, I also view care management as something which we are presently already doing. We do not see that as a health-related function. We see that as a whole continuum of service.

As I said in my testimony, we have adult day care. We have health promotion, health maintenance, I and R, legal assistance, outreach, respite. We have Alzheimer's services. We have the whole thing.

To us, care management is just that; it is every service that we are providing which is going to help that person to remain out of that institution.

Senator MATSUNAGA. Thank you very much.

Now, Ms. Ferguson, you suggest changes in the Act be made to contain a proposal for permitting States to establish mandatory cost-sharing for services. What effect do you think this would have on participation; that is, what evidence is there to show that mandatory cost-sharing will not decrease participation by those who are most in need of services?

Ms. FERGUSON. Well, Senator, we are talking about demonstrations at this point rather than across-the-country, mandatory cost-sharing. We are talking about several demonstrations.

Senator MATSUNAGA. I see.

Ms. FERGUSON. I said in my testimony that many State agencies on aging are involved in much more than just the administration of Older Americans Act funds. State agencies on aging frequently have service money from many other programs.

In those programs, we already have examples of State agencies using sliding fee scales, and their experiences indicate that older persons support these policies where they exist.

Senator MATSUNAGA. My fear is that expressed also by Dr. Dusenberry; that is, if cost-sharing is imposed, would not some type of means test then be required? You do not have that fear?

Ms. FERGUSON. There would be no cost-sharing for low-income people, specifically those with incomes below 150 percent of poverty. Persons with incomes above that level would not be excluded from the program. These persons would pay for part of the service costs.

We have some difficulty coordinating the diverse programs we administer. This change could help us catch those people who sometimes fall between the cracks of various programs. It avoids the real confusion that older people feel when they may go to a department of social services if they need, for example, home care and find that through the Medicaid program there is a co-payment. If they go to an area agency, there is not a co-payment under title III.

It can be very confusing to people. We think this would allow each State to establish a systematic approach to the provision of services supported by the total myriad of funding sources.

Senator MATSUNAGA. Now, Mr. Reilly, there has been a suggestion made that legal services to the elderly receive at least six percent of each area agency's funds. Now, what is your reaction to such a suggestion?

Mr. REILLY. Well, I hate to argue with my legal service compatriots, but I think that one of the basic, very good principles of the Older Americans Act Title III is the testing of the waters in terms of local needs by the area agencies, looking at the resources, prioritizing them, and developing an area plan.

It seems to me a sounder way to go to leave the amount that would go to legal services, which is indeed a very valuable service, but to leave that up to the local planning process because once you step into the arena of fencing off portions of the money for one or another service, it is very difficult to not go down that list of services and find lots of others that a similar case could not be made for a specific set-aside.

Senator MATSUNAGA. Well, I wish we could continue more on this quiz program, but time is fleeting by, and I thank you all.

Ms. LLOYD. Mr. Chairman?

Senator MATSUNAGA. Yes.

Ms. LLOYD. May I ask a favor. I have never testified with the red light before, but I would sure like to suggest that to our State legislature. I did not finish my testimony. May I ask that the complete testimony be made a part of the official record?

Senator MATSUNAGA. Yes. Your statement will be included in the record as though presented in full.

Ms. LLOYD. Thank you.

Senator MATSUNAGA. Our next panel of witnesses will include Mr. John Pickering, who is the Chairman of the American Bar Association's Commission on Legal Problems of the Elderly; Ms. Elizabeth Crittenden, President of the National Institute of Senior Centers; Ms. Jill Duson, President of the National Association of State Long-Term Care Ombudsmen Programs; Ms. Alice Smitherman, President of the American Dietetic Association; and Ms. June Durham, a board member of the National Association of Meals Programs.

Now, this panel will be addressing issues of concern under Title III of the Older Americans Act, which provides both support services and nutritional services to the elderly.

We would be happy to hear from you, Mr. Pickering.

STATEMENTS OF JOHN PICKERING, CHAIRMAN, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AMERICAN BAR ASSOCIATION, WASHINGTON, DC; ELIZABETH CRITTENDEN, PRESIDENT, NATIONAL INSTITUTE ON SENIOR CENTERS; CHARLESTON, WV; JILL C. DUSON, PRESIDENT, NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS, AUGUSTA, ME; ALICE L. SMITHERMAN, PRESIDENT, AMERICAN DIETETIC ASSOCIATION, ALEXANDRIA, VA; AND JUNE DURHAM, BOARD MEMBER, NATIONAL ASSOCIATION OF MEAL PROGRAMS, GREENVILLE, SC

Mr. PICKERING. Thank you, Mr. Chairman. I am John Pickering. I am representing the American Bar Association, and I chair its

Commission on the Legal Problems of the Elderly. I have submitted a prepared statement, which I shall summarize, and request that it be placed in the record.

Senator MATSUNAGA. All of your statements, I might say, will appear in full in the record.

Mr. PICKERING. Thank you.

We are very pleased that you are having this hearing today because it is of such great importance to the nation's elderly. The American Bar Association has long been interested in the delivery of legal services, both through the Legal Services Corporation as well as the Older Americans Act.

We seek to promote the development of legal resources for older persons generally and, in particular, to further involve the private bar in responding to the needs of the elderly. Thus, we have great interest in the sections of the Older Americans Act pertaining to legal services.

Our Commission, with the help of the National Senior Citizens Law Center and the Legal Counsel for the Elderly of the American Association of Retired Persons, conducted last year a survey of Title III legal assistance providers. The results of that survey are set forth in a white paper which we have furnished to this Subcommittee and which we have previously given to the House Select Committee on Aging.

Our survey confirms that despite very considerable efforts both by the public and the private sector, many older people still do not have adequate access to legal assistance. Our white paper surveys the field, discusses the problems, and suggests certain remedies.

On the basis of that survey and our experience, we are recommending nine changes to strengthen the Act and three changes in the accompanying report language. I shall not take the time to list all of those; we think they are all important. I would like to mention briefly four which we particularly urge.

The first is one that has already been referred to, and that is our recommendation that at least six percent of the amount of Title III-B priority funds allotted to each area agency on aging should be spent on each of the three priority services to maintain the same level of effort as was achieved in fiscal 1980.

Now, we appreciate the need for local autonomy, but unfortunately we find that in some areas in some of the agencies nothing is being done to carry out the priority requirement of the Act. We are not necessarily wedded to six percent, but we think that something more than just adequate proportion language needs to be in the statute, and we are not limiting that simply to legal services, but to the other priority areas, the in-home supportive services and the social services as well.

Our second recommendation is that there be a $10 million supplemental grant to the States. This would be in addition to the Title III-B funding and, together, would, we estimate, bring the total effort back up to fiscal 1980 levels, which was the last time that the Administration on Aging collected statistics. The results of our survey indicate that we are falling behind and that at least 15 to 20 percent of the AAAs are not funding any legal services for elderly people.

Our third recommendation is that it be made clear that voluntary contributions should not be required for legal assistance. The only provision in the statute dealing with voluntary contributions is in relation to nutritional services.

We fear that asking people to contribute for legal services will have a chilling effect. Many of the people in need of legal services are afraid of the costs, and so on, and may be disinclined to ask for the legal services. We think that should be made clear.

Finally, our last recommendation that I would like to emphasize particularly is the recommendation that a private right of action be granted both to grantee agencies and to beneficiaries themselves. There have been various examples of failure to carry out the provisions of the Act and we think a private attorney general provision would be a salutary one.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Pickering follows:]

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Statement of
John Pickering, Chair
Commission on Legal Problems of the Elderly

on Behalf of

The American Bar Association

Before the
Subcommittee on Aging
of the
Senate Committee on Labor and Human Resources

Comments on
The Reauthorization of the Older Americans Act:
The Legal Assistance Provisions

April 30 1987

My name is John Pickering and I am here today representing the American Bar Association. I am the Chairman of the Association's Commission on Legal Problems of the Elderly. This Commission was created by the ABA in 1978. It is a fifteen-member, interdisciplinary group that includes practicing attorneys, legal educators, gerontologists, elderly law specialists, government officials and senior citizen advocates.

We are very pleased that you are having this hearing today because it is of such great importance to the nation's elderly. The ABA has long been interested in the delivery of legal services through the Legal Services Corporation as well as the Older Americans Act. In 1981 the ABA Board of Governors passed a resolution urging that the Older Americans Act of 1965, as amended, be reauthorized and that a high priority continue to be placed on the delivery of legal services to the needy elderly. During that same year the ABA organized state and local bar associations throughout the country to assure that the Legal Services Corporation remain in existence and be fully funded.

One of our Commission's priority areas is the provision of legal services. The Commission seeks to promote the development of legal resources for older persons generally, and in particular to further involve the private bar in responding to the needs of the aged. Thus, we have great interest in the sections of the Older Americans Act pertaining to legal services.

The delivery of legal services to the elderly takes many forms. The Commission over the years has sought to work with law school clinics, continuing legal education programs, lawyer referral agencies as well as those legal assistance providers funded through the Older Americans Act and the Legal Services Corporation. In particular, our Commission and staff have worked with Title III B funded legal assistance providers, the state legal services developers as well as bar associations, pro bono volunteer programs, and private attorneys to try to assure that the legal needs of the nation's elderly are being met. Despite considerable efforts, we find that many older people still do not have access to legal assistance.

The Commission with the help of the National Senior Citizens Law Center (NSCLC) and the Legal Counsel for the Elderly of the American Association of Retired Persons conducted a survey of Title III legal assistance providers in August 1986, drafted a preliminary position paper in October 1986, and held a seminar with legal service providers during the annual meeting of the National Legal Aid and Defender Association. The final paper was presented to the House Select Committee on Aging's Human Resources Subcommittee at a hearing on January 29, 1987 and copies of it are being presented herewith at this hearing.

The White Paper was prepared to gather the facts and pose issues for discussion by members of the Congress about the legal assistance provisions in the Older Americans Act. The OAA has contained authority and direction for the provision of legal assistance since the early 1970's.

The Paper contains a description of the system, the legal problems currently facing older people, examples of how legal assistance providers resolve these problems, and recommendations for changes in the OAA authorization language.

In our survey we received responses from over fifty legal assistance programs from across the United States. The survey explored the level of funding, the kinds of procedures used to fund legal assistance providers, the definition of legal assistance, and the definition of "unit of service" as well as other issues.

The White Paper discusses the problems regarding legal assistance funded by area agencies on aging through the Older Americans Act. No statistics have been kept at the national level since 1982 as to the number of AAA's that have funded legal assistance, nor the amount that was funded. In 1982 only 85% of the AAA's were in compliance with the OAA. Since that time the limitations on growth in the funding of all aging programs has further diminished the amount of money available for legal assistance. At the same time, cut-backs in domestic federal programs have increased the need for advocacy and legal assistance. In the light of the problems found, the White Paper addresses the relevant issues that should be considered during the next few months for the reauthorization of the OAA and its provisions for legal assistance for the elderly.

On the basis of our survey and experience, we are recommending nine changes to strengthen the statute and three changes in the accompanying report language. The nine suggested statutory changes are:

1. a minimum of 6% funding for all Title III B Priority Services;
2. $10 million in supplemental funding for legal assistance;
3. a private right of action for agencies as well as beneficiaries;
4. earmarking of specific funding in Title IV for training, research and special projects;
5. a study to determine how dollars are being spent in priority services in Title III B;
6. clarifying reporting requirements so that they may realistically reflect what legal assistance providers actually do;
7. a clarification of the definition of legal assistance, emphasizing the statutory language
8. establishing hearing requirements; and
9. assurance of confidentiality.

The three suggestions for report language deal with:

1. a definition of the position of Legal Services Developer;
2. enforcement of priority services; and
3. clarifying the policy regarding donations.

As you put together your reauthorization bill the ABA would be happy to work with you on specific language for your legislation. Meanwhile I would like to emphasize some of the most important issues.

1. At least 6% of the Amount of Title III B Funds Allotted to Each Area Agency on Aging Must Be Spent on Each Priority Service to Maintain the Same Level of Effort

A review of the legislative history of the Older American's Act reveals that Congress was concerned that, in the absence of national direction, legal services for older people would not be sufficiently funded at the local level. In 1975, after 10 years of experience with the Act, Congress found that Title III money was being spent on a scatter-gun array of services and that critical services were not adequately funded. Thus in the 1975 amendments to the Act, Congress set national priorities for the states to assure that at least the most important services, including legal assistance, would be adequately funded.

In 1978, Congress increased the percentage of funds to be spent on priority services and required that some funds be spent on each mandatory priority including legal services.

This change did have a positive effect. Funding for legal services increased from 5.4 million in FY'78 to 12.9 million in FY'80. The average AAA spent 6.06% of Title III B funds in Legal Services in FY'80.

Since that time AoA has stopped collecting statistics on the amount of funding spent on the priority services. However, the perception in the field is that the funding has decreased over the past years and that some AAAs (estimated to be 15-20%) do not fund any legal services for older people.

The establishment of a floor of 6% would restore funding percentages to at least FY'80 levels and would insure that all AAAs comply with the national priorities set in the Older Americans Act.

AAA's who are currently funding at levels above 6% should be required to maintain this effort so that the funding floor does not become a funding ceiling.

2. $10 Million in Supplemental Funding to the States is Necessary to Maintain Legal Assistance at 1980 Levels

We recommend that the Older Americans Act be amended to authorize that the sum of $10 million be allocated to the states to enter into grants and contracts for the provision of legal assistance to older persons.

This provision would allow supplemental funding under Title III to the states. Funding for legal assistance under Title III in 1980 has been estimated at $12.9 million. Because of the actual decrease in funding since that time, the additional sum of $10 million is recommended as that amount necessary to restore legal assistance to the elderly to 1980 levels, adjusted for inflation.

This additional funding provision is intended as one that is supplemental to regular funding of legal assistance through area agencies as a priority service under Title III(B).

The Act provides for an allocation of Title III funds based on each state's elderly population. 42 U.S.C. section 3024. This formula can be utilized under this recommendation to afford the states discretion to use any additional sums in those areas of greatest legal need.

3. The Donations Policy in Section 307(a) (13) Provides for Voluntary Contributions to the Nutrition Project. Seeking Voluntary Contributions for Legal Assistance Should Not Be Permitted

The OAA statutory language states that nutrition projects will permit grantees to solicit voluntary contributions for meals. The Senate Report on the 1984 OAA amendments also specifically targets "contributions for services" in the context of the nutrition project. (Report No. 98-467, 98th Congress, 2nd Session, p. 18) The Federal regulations implementing the OAA are codified at 45 C.F.R. §1321 et seq (April 1, 1985) §1321.69 attempts to implement the voluntary contributions language from the Act by broadening the scope to include all services.

There is no direct tie between the language on contributions and the legal assistance providers which would allow either voluntary or fee schedules for legal assistance. Section 307(a)(15) of the OAA and its subparts outline the provisions of legal assistance. Section 307 is silent on the question of contributions from recipients. It does not expressly require nor allow for voluntary contributions. This is an important "silence" as the OAA specifically addresses contributions to services with respect to the nutrition projects. Section 307(a)(13)(c)(i)(ii) is the only place in the Act which refers to voluntary contributions from beneficiaries.

There is a potential harm to clients who might be hesitant to seek legal assistance. It is the intent of the Act to target services to those in the greatest economic and social need. Due to beneficiaries limited resources and knowing what the cost of legal assistance might be high, a requirement for contributions might inhibit older people in seeking legal assistance.

We strongly urge you to reauthorize the Older Americans Act and to continue to place a priority on the delivery of legal services to the elderly.

On behalf of the American Bar Association and our Commission, I thank the Chairman and the Subcommittee for permitting us to present these views. And we hope that our White Paper will be a substantial help in the consideration of this important legislation.

Senator MATSUNAGA. Thank you very much, Mr. Pickering.

We will now be happy to hear from Ms. Crittenden.

Ms. CRITTENDEN. Thank you, Mr. Chairman, for the opportunity to speak here today on behalf of the National Institute of Senior Centers, which we call NISC. NISC is a sub-unit of the National Council on the Aging.

In the few minutes I have here today, I would like to highlight one or two of our major concerns and attempt to personalize some of the issues that you will be considering in the coming weeks and months.

One of the unique things about multi-purpose senior centers is that the elderly think of them as their place. We have worked hard at cultivating the image of senior centers as true centers of senior activity, places where seniors can come to socialize, to learn, and to stay involved in society.

Certainly, every elected official in West Virginia knows where the local senior center is, and that it is the place to come and meet large numbers of active senior citizens. Perhaps we have been too successful in cultivating the image of senior centers as wellness centers, and if I can only accomplish one thing by my appearance here today, I hope it will be to convince you that a multi-purpose senior center is more than a recreation center. It is a place where the elderly can access important and needed services in an atmosphere that they find acceptable.

Linking older folks to supportive services has traditionally been difficult because of the reluctance of senior citizens to "ask for welfare." Under the Act, we have had more than 20 years of history of universal availability of services to all older people.

Without means testing, it has been possible for the elderly of all socio-economic groups to come to senior centers and other Older Americans Act-funded programs and receive services while maintaining their sense of pride.

I have seen friendships spring up between, for instance, a retired university professor and a retired glass plant worker with only a third-grade education. Mandatory means testing and fee structures would inevitably build barriers and impose a very real threat to the availability of services under the Act without any assurance that more services would be made available or that existing services would be better targeted.

Similarly, raising the eligibility age for services to 70, as proposed by some, would decrease the acceptability of programs funded under the Act while shutting out many who need services most.

I am particularly thinking of the "young old"; for instance, the recently widowed who is suddenly faced with new responsibilities and yet is not considered old enough to receive benefits from, say, pension programs or Medicare.

I know of one 61-year-old woman in Alabama who began participating at the senior center with her husband as part of the travel club. A year or so ago, he died. Soon, in her loneliness, she started coming to the center for craft classes and for the Title III–C nutrition program.

Faced with failing health and a confusing array of insurance and medical bills, she now seeks help at the center on how to handle these new responsibilities. Now, she is still relatively young by our standards, but there is no doubt in my mind that without easy access to these services in an acceptable environment, society would soon be faced with providing her with much more expensive services in a much more formalized institutional setting.

Let us not forget that aging is not a disease. The Older Americans Act should not be turned into a sub-component of the Medicare/Medicaid system. Let us instead take our inspiration from the 99-year-old woman in Putnam County, West Virginia, whom I recently heard on our television news was designated a hometown hero because of her work on a volunteer basis of coordinating the Title III-B-funded transportation services in that rural community.

I would prefer to concentrate on the positive things that have been or could be accomplished under the Act. It took five years of advocacy, but the senior citizens in West Virginia were the leading force in getting the generic drug legislation passed there, and implemented there, by the way, although implementation was often more difficult than getting it passed.

Because our area agencies took seriously their responsibilities for advocacy under the Act, we all became involved in this important effort. As a side benefit, we saw many seniors who had never engaged in public affairs become empowered to speak for themselves and others on numerous issues.

NISC hopes that Congress will make it clear to the Administration on Aging that the advocacy efforts required by the Act should be carried out notwithstanding the prohibitions of OMB Circular A-122 and similar mechanisms designed to stifle the collective voice of people.

Similarly, fully implementing the focal point concept already a part of the law and promoting the nationwide adoption of standards for the management of senior centers and other services providers under the Act are positive steps which should be taken in the authorization process.

Let us hope that after the toil and struggle of the reauthorization we can all feel as good about ourselves as a woman I recently heard about from Indianapolis who is a member of a senior citizens chorus that was asked to sing at the rededication of a newly renovated senior center housing complex. She informed those around her that for 25 years when that building was a hotel she had scrubbed that very floor as a maid. She said, "and tonight I come back as a star." So perhaps we can take a lesson from the elderly who participate under this Act.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Crittenden follows:]

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REAUTHORIZATION OF THE OLDER AMERICANS ACT

Testimony by

Elizabeth Crittenden

The National Institute of Senior Centers

Before

The Aging Subcommittee

of the

Senate Committee on Labor and Human Resources

(The National Institute of Senior Centers is a constituent unit of the NCOA)

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I. Introduction

In the more than two decades since the passage of the Older Americans Act, senior centers have been an essential part of the aging services network striving to improve the lives of our nation's elders. Senior centers are truly centers of senior activity, serving as natural and acceptable locations for the delivery of and access to needed services. As wellness centers, senior centers help prevent the unnecessary institutionalization of the elderly by involving participants in preventive programming in the relatively early stages of the aging process. As participants "age in place," senior centers serve as the focal point for access to and delivery of needed support, both formal and informal. Senior centers are a vital component of the continuum of care established in concert with the Older Americans Act. The system built under the Act serves our nation's elderly with sensitivity and cost effectiveness. The National Institute of Senior Centers (NISC) calls on Congress to reauthorize the Act with only minor modifications.

II. AoA Proposals

Even though Congress is well into the reauthorization process, the Administration on Aging has yet to publicly advance specific proposals for amending the Act. Nevertheless, based on individual statements and unconfirmed information NISC has reached certain conclusions regarding the administration's thinking, and we are opposed to most of it.

Apparently, the AoA would consolidate the funding for the three current programs under Title III of the Act into a single "block grant" with no meaningful guidelines as to how these funds should be allocated in state plans. While the administration justifies this move as providing greater flexibility to the states, we note that Section 308(b)(3) of the Act already allows the transfer of up to 20% of the appropriated funds between programs. The AoA does not cite, nor is NISC aware of, any great hue and cry among state units on aging for increased flexibility. This move on the administration's part toward "greater flexibility" seems little more than a smoke screen for block granting services under the Act. If this is correct, NISC sees such block granting as an ominous sign, since block granting under other statutes has quickly led to drastic cuts in funding based on presumed administrative savings. Even without funding cuts, block granting Title III would apparently mean the abandonment of Section 306(a)(2)'s requirement that an adequate proportion of funds be allocated to designated services.

After giving lip service to the need for greater flexibility in its proposal to block grant Title III, the bulk of the administration's proposed amendments would force state, area, and local agencies to give top priority to targeting the limited dollars provided by the Act toward our oldest, most vulnerable citizens. Thus, the AoA is urging Congress to narrow the continuum of care made possible under more than two decades of programming under the Act. NISC urges Congress not to disenfranchise our senior citizens under seventy, but to allow the existing system to continue to function, planning services with and for the broad spectrum of the elderly population in response to locally defined needs.

Raising the age by which funds are allotted under the Act from 60 to 70 will inevitably lead to State Plans which increase the age for eligibility for services. The AoA recognizes this inevitability in pointing out that the change in the allocation formula is designed to target more Title III funds toward vulnerable older persons. The proposed move to age

70 would roll back the aging services network to where we were 15 years ago. An increased eligibility age will lead to fewer, more expensive services for fewer people, diminished accessibility and acceptability of services through senior centers, and the demise of prevention programs. The relatively miniscule funds made available through the Act cannot possibly meet all of the needs of our vulnerable senior population. It is true that our society must respond to the need for adequate Health and Social Services but sacrificing existing programs through the medicalization of the Act is not a rational way to begin that response. We need to move forward, not backward, and we need to involve more seniors of all ages in our programs so that they can stay well longer and continue to contribute to each of our communities.

NISC opposes any amendment to the Act which would allow the establishment of mandatory fee structures for services funded under the Act. Such a policy would be in conflict with the Act's more than 20 year history of the universal availability of services to all older people.

Participants in senior centers, like other current recipients of services under the Act, are "aging in place." As these people need different services, local providers and area and state planners will, given the current requirements of the Act, learn of and respond to these changing needs. NISC believes that is is far better to allow such changes to take place naturally, in response to local needs than to have the federal government dictate its priorities nationwide.

III. NISC Proposals

Standards. Section 202 of the Act should be amended to require the AoA to support implementation of the Senior Center Standards originally developed by NISC by promoting the nationwide adoption of standards for the management of senior centers. The NISC developed standards have been received nationally as useful tools helping senior centers to enhance the quality of their staff and services. The OAA money initially expended toward the development of these standards should not be allowed to go to waste; the AoA should be required to implement these standards in as widespread a fashion as is feasible, providing training and technical assistance where needed.

Focal Points. Congress should make clear its intent that the current language in Section 306(a)(3) of the Act requiring the designation of focal points for the delivery of services be fully implemented, and that such focal points be given consideration in the service funding process. In this fashion, community focal points will become the local partners of area and state agencies in providing optimal services for our senior population.

Adequate Proportion of Funding. Section 306(a)(2) should be amended to include Community Services as one of the categories which must receive an adequate proportion of funding under each area plan, thus making it clear that Congress recognizes the importance of the provision of these services through organizations such as multipurpose senior centers at the community level.

Funding Levels. Congress should establish adequate authorization levels for funding each of the existing titles of the Act.

IV. Proposals by Congress and other organizations

NISC feels that Title III B is adequately flexible to provide the services contemplated by the proposed Title III D. If, however, after its hearings and deliberations the Congress sees fit to include this new section in the Act, NISC recommends that it be designated "In-Home, Adult Daycare, and other Community Based Services for Frail Older Individuals," that senior centers would be among the recipients of funding under this section, and that at least 25 million additional dollars be appropriated for these services.

NISC, in principal, agrees with the concepts advanced by the National Association of Area Agencies on Aging and the National Association of State Units on Aging in calling for:

- amending Section 306(a)(6)(D) to make it clear that the advocacy efforts required by the Act should be carried out notwithstanding any prohibitions of OMB Circular A-122; or IRS regulations on non-profit lobbying;
- adding language to the Act indicating the desire of Congress to limit the civil liability of the ombudsman program and other programs funded under the Act.

NISC also supports the recommendation of the National Governor's Association for the continued provision of wellness and health education in senior centers.

NISC strongly opposes the proposal by the National Association of Area Agencies on Aging to establish a waiver for direct service provisions for case management.

V. Conclusion

The Older Americans Act has served this nation well since 1965. The basic provisions of the Act are sound and it has enabled the development of a planning, advocacy, and service network upon which millions of our nation's elderly now rely. NISC calls upon Congress to continue the good work accomplished under the Act and allow the current system to continue growing and evolving to meet the needs of an aging population.

Senator **Matsunaga**. Thank you.

We will be happy to hear from you now, Ms. Duson.

Ms. **Duson**. Thank you, Mr. Chairman. Thank you for the opportunity to testify today, and I would like to express on behalf of the National Association of State Ombudsman Programs our appreciation for the attention that has been focused on restructuring of the ombudsman program and strengthening the advocacy tools of our network.

My name is Jill Duson and I am the State ombudsman for Maine and President of the National Association of State Ombudsman Programs. The ombudsman association circulated a ranking form to its membership in response to a variety of bills that were introduced in the last session, a bill that was reintroduced by Senator Glenn in this session, a bill that has been recently introduced by Congressman Bonker in the House this session.

Ombudsmen responded to that ranking sheet giving priority to some of the changes that have been suggested, reflecting their priorities for what they thought would be the most important changes to occur under the Act, and I would like to express what those priorities are.

The Association supports the creation of a separate Title III-D, which would require operation of an Office of State Long-Term Care Ombudsmen. We view this change as more than semantics. It is a functional change that will allow the office to function at the State level, assuring some quality control in the operation of our complaint investigation procedures.

As you may know, a lot of the day-to-day complaint investigations in long-term care facilities are conducted by local ombudsmen programs. The State programs would like the Act to give some instruction and direction for standardizing the training that the State offices must provide to those local ombudsmen and extending some powers and protections to those local ombudsmen by virtue of their connection with the State office.

Some of those specific protections, just to be fairly quick about it, would be protection from liability for good-faith performance of their duties, an extension of access to legal counsel should they be the brunt of a lawsuit or other action that results from complaint investigations, and basic conflict of interest restrictions on both the entity which would designate who shall serve as State ombudsmen and on the State ombudsman in his or her designation of who shall operate as local ombudsmen.

There are a couple of other points detailed in my comments, but those are the major issues, in addition to which we would emphasize the need for a clear exemption from OMB Circular A-122.

Next, I would like to touch briefly on funding issues. It will come as no surprise to you that ombudsmen, of course, support more funding for ombudsmen programs. The program funding has not been adjusted since it was incorporated into the Act in 1978.

We would support the recommendation that came out of the Institute of Medicine study which recommended a base funding level of $100,000 for ombudsmen programs. We would also request, however, that should there be additional funds assigned to the ombudsman program that accompanying "hold harmless" and "maintenance of effort" type language is necessary to protect our current funding.

If the Congress should decide not to provide new funding for ombudsmen programs, we would urge in the alternative that you consider implementing those provisions which would strengthen our operations which do not cost money, and there are quite a number of those.

Lastly, I would like to touch on home care advocacy because that has been an issue of concern from many quarters. I think that ombudsmen recognize that, clearly, folks who receive home care services need an independent advocacy system.

It just does not make sense to provide to Ms. Smith alternatives to nursing home services and if she chooses those alternatives but has a problem in the delivery of services under that system, there is no independent source where she can go for help in addressing those problems.

We would, however, urge the Congress to move incrementally in developing a system for home care advocacy. We would suggest a system fairly similar to that which resulted in the inclusion of the long-term care ombudsman program in the Older Americans Act; more specifically, providing demonstration funding as a first step for those States that wish to develop models for home care advocacy, evaluating those models, and then proceeding to make broad national policy decisions about home care advocacy.

Thank you very much.

[The prepared statement of Ms. Duson follows:]

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April 30, 1987
Testimony of Jill C. Duson, President-NASOP

Senate Committee on Labor and Human Resources

Subcommittee on Aging

I am Jill Duson, State Ombudsman for the Maine Committee on Aging, Long Term Care Ombudsman Program, and President of the National Association of State Long Term Care Ombudsman Programs (NASOP). I am pleased to present the comments of the Association on issues relating to the reauthorization of the Older Americans Act.

The NASOP provides information, assistance, and professional development support to its members, the 52 State Long Term Care Ombudsman Programs. The Association provides a national voice for ombudsman participation in the development of public policy relating to the needs of long term care consumers. In addition, the Association provides a channel for involvement in national efforts to strengthen the capacity of the ombudsman/advocacy system.

Since its incorporation into the Older Americans Act (OAA) in 1978, the State Long Term Care Ombudsman Programs have become an integral component of the advocacy responsibilities of the state units on aging. The 1978 amendments, required the designation of a person to operate the Ombudsman Program and specified four broad mandates for program activities:

i. Complaint Handling
ii. Legislative Advocacy
iii. Administrative Advocacy
iv. Volunteer Training and Citizen Involvement

As the 10th anniversary of the incorporation of the program into the act approaches, Ombudsman welcome the attention which individual Congressmen, various Congressional Committees, and the network of interested National Organizations have focused on a review of program structure and the development of proposals to strengthen program effectiveness. Our membership is particularly pleased to have this opportunity to discuss proposed amendments to those portions of the Act which relate to the Ombudsman Programs with the Senate committee responsible for reauthorization.

NASOP

SUMMARY OF COMMENTS--OLDER AMERICANS ACT REAUTHORIZATION

I. Operation of the LTC Ombudsman Program

NASOP supports the creation of a **Title III-D** requiring operation of an **Office of the State Long Term Care Ombudsman**.
The Title should:

- establish core rights, duties, and protections which extend to the operations of the "office" and its designees.
- require procedures to ensure access to facilities, residents and resident records, and state agency records.
- provide a clear exemption of the Office from A122 restrictions.

II. Advocacy for Home Care Consumers

A handful of Ombudsprograms have expanded to cover home care consumers through state action. It is premature to address home care quality assurance by national mandate. Instead, NASOP recommends that the Act be amended to:

- provide demonstration funding for development of model home care advocacy systems and
- commission a national study to review/evaluate program models and develop recommendations for national policy.

III. Training needs of Ombudsman

Funds should be provided to the Administration on Aging to:

- support a National Ombudsman Training Program and to provide orientation for new ombudsman.
- establish a national clearinghouse function to support ombudsman programs.

IV. Funding Issues

Ombudsman programs need an appropriation to increase base funding levels to $100,000 (under a new Title III-D or within the current Title III-B) with additional funds available based on a specific formula. NASOP recommends that:

- adoption of a Title III-D include **hold harmless** language to protect against loss of current state and federal funds.
- in the absence of additional funding, substantive amendments which do not require new monies should take effect upon reauthorization.

State LTC Ombudsman and program staff reviewed proposed changes to the Older Americans Act at the October '86 Membership Meeting of the Association. As a follow-up to that review, state Ombudsprograms have responded to a ranking form distributed by the Association in January '87. The following comments are offered on behalf of the national network of State Long Term Care Ombudsman Programs.

I. Operation of a the Long Term Care Ombudsman Program

Section III-B of the OAA requires the SUA to develop a uniquely identifiable entity: the State Long Term Care Ombudsman Program. It also requires the designation of a specific individual to carry out mandated program responsibilities. As is the case with many OAA programs, however, the Act leaves to the states a great deal of discretion in the actual design and operation of the Ombudsman Program. The flexibility reserved to the states has resulted in a variety of program models each of which is uniquely suited to local realities and needs. State Ombudsman believe that there are ways to strengthen the capacity and effectiveness of ombudsman programs in responding to the concerns of long term care consumers, without damaging individual state flexibility.

We urge your consideration of the following proposals which seek to establish a universal set of specific program powers and duties.

A. Placement of the SLTCOP's in a Separate Title

We support the creation of a Title III Part D requiring each state to operate, either directly or by contract, an **Office of the State Long Term Care Ombudsman**. In concert with this change, the Act should provide a matrix of specific powers and duties for the ombudsman programs. We support the separate title proposal as a means of establishing core functions for program operation and against which program performance can be measured.

OAA assignment of ombudsman program functions to an "office" within the state unit on aging (or other entity operating the program) would provide a context within which specific program operation needs may be addressed. Paramount among these needs is the ability to formally **designate** local programs and individual volunteers to act as **representatives of the "office."** This clarification of program status will establish an umbrella entity from which additional federal OAA protections may flow to the operations of the office, and its designees.

The specific protections which State Ombudsman feel are critical to strengthening the ability of the program to operate include:

1. **protection from liability** for the program and its designees while engaged in the good faith performance of official duties.
2. "**whistle blower**" protection for individuals who report concerns or cooperate with investigations by the office.
3. penalty for interference investigations by the office.
4. provision of adequate legal counsel to any representative of the Office against whom suit is bought in connection with the performance of official duties.
5. specific **conflict of interest** restrictions on the entity which houses the Office and designation of representatives of the Office.

In addition, Ombudsmen strongly support language under the new title which would require establishment of procedures to **ensure access** by representatives of the office to:

...**facilities** (nursing and boarding homes and other treatment settings covered by the office)
...all **residents and resident records** held by the facility (with procedures to protect resident confidentiality) and;
...**records of agenciess** responsible for oversight of facilities or residents within the jurisdiction of the office.

Finally, Ombudsman support the proposals which would clarify that the activities of the Office shall be exempt from the **A-122 restrictions** on interaction with legislative entities. Ombudsmen have a responsibility under the Older Americans Act to monitor laws and regulations relating to long term care facilities, residents' rights and benefits, changes within the regulatory framework, and other areas impacting on the lives of residents.

Long term care consumers lack the resources to constructively put forward their concerns and ideas and effectively advance public policy objectives. The Ombudsprograms are excellent sources for identifying problems and pointing out positive and negative trends within the system. The Older Americans Act recognized this advocacy duty, and therefore, we believe that Circular A-122 does not apply to ombudsman programs. Application of the restrictions to the SLTCOP will force them to function as mere case work programs without the key element of using case experience to identify issues and advocate for systemic changes on behalf of these consumers.

Ombudsman have written letters to the Administration on Aging requesting clarification of Circular A-122 and its relationship to ombudsman programs. Our inquires were referred to OMB with no response in over two years. This inaction has had a chilling affect on some programs and has become an impediment to effective systemic advocacy.

Establishment of the "office" and requirements for specific core components within the Act, will ensure that individual state programs will have at their disposal the necessary tools to operate quality ombudsman/advocacy services. A collateral benefit of these changes will be to promote the development of management and professional performance standards against which program performance can be measured.

II. Advocacy for Consumers of Home Care Services

There have been a number of proposals to expand the duties of the Long Term Care Ombudsman into areas not associated with its' traditional activities of advocating on behalf of individuals residing in long term care facilities, specifically nursing homes and boarding care facilities. Many ombudsman respond to suggestions of expansion by pointing out the present inadequacies in funding for our traditional duties, particularly in the area of board and care facilities. We are motivated by a desire to insure that current advocacy responsibilities are not diluted by new federal mandates. Areas which have been suggested which might benefit from ombudsman intervention include: home health; hospitals or acute care in the areas of discharges and DRGs; the Veterans Administration homes; hospice, and LTC/Medigap Insurance. Due to increased attention from Congress and other Aging organizations to expand long term care ombudsman duties, ombudsman have worked to develop a clear position on program expansion.

A handful of state long term care ombudsman programs have entered into contracts or have been mandated by their states to engage in expanded activities particularly in the areas of home health and acute care. The ombudsman who are involved in these activities are developing strictly defined procedures or policies to insure that limited resources are not overtaxed. Other ombudsman have resolved cases involving home care and acute care on an individual basis. In these cases, we have taken on responsibilities in lieu of leaving a consumer with no source of help in dealing with their concerns.

Clearly, **consumers of home care services need an independent advocacy system**. It is premature however, to address this need with a broad brush assignment of home care quality assurance to the state units and area agencies.
It is also premature however, to expand the long term care ombudsman program to cover this population.

In the alternative, NASOP recommends consideration of the following actions related to home care advocacy:

1. Provide funding for research, demonstration and training **grants** related to the development of model Home Care Advocacy Systems.
2. Commission a **national study** to review SLTCOPs which have expanded pursuant to state mandate, to assess impact on program financial, training, personnel resources; and impact on program activities on behalf of nursing and boarding home residents.

The study should be funded through the Administration on Aging and contracted out to an appropriate agency with a strong record of long term care involvement and commitment. The agency awarded the contract must involve the NASOP and /or other interested parties throughout the entire process via an advisory committee. The results of the study should be shared with Congress and the entire aging network before any federal action on expansion of the Ombudsman Program.

III. Training Needs of Ombudsman

Another key to providing nursing and boarding home residents with capable and competent ombudsman services, is assuring that ombudsman are informed about emerging long term care issues and trends impacting on residents, negative facility behavioral patterns and state responses to those patterns including laws and regulations. In addition, summary information on each state's ombudsman activities, resources developed, and special projects needs to be shared.

To meet these goals the Administration on Aging should develop, with ombudsman input, a national training program which includes an orientation program for new ombudsman and an ongoing training system to address emerging problems/issues identified throughout the various state programs. In addition to training, a national clearinghouse function must be established through which we can share information and identify helpful resources.

IV. Funding Issues

Current OAA minimum funding requirements of 1% of III-B funds or $20,000, whichever is greater, is insufficient to support service delivery to program clientele who make up over 5% of the elderly population. We recommend adoption of a funding formula which ensures that each office; (whether in a state unit on aging or free standing) can operate an adequate statewide program: a program with sufficient staff and resources to do the job.

A new formula should include a review of base funding requirements which have not been adjusted since 1978. Any new formula should consider elderly population statistics, the number of nursing and boarding care beds, geographic coverage and other factors. The Institute of Medicine study of long term care issues included several recommendations for strengthening the LTCOPs including provision of a **new base funding level of $100,000**. The NASOP recommends a base funding of at least $100,000 and urges the Committee to consider this figure in the context of the growth in numbers and care needs of the populations which we currently serve.

The Committee has been presented with two options. If the Committee opts for creation of a Title III-D to cover the Ombudsprograms, an increase of the base funding to $100,000 per program, with additional funds distributed in accordance with a specific formula must be considered.

In addition, it is important to add hold harmless language which will prevent the diversion of OAA funds currently committed to ombudsman activities. To fail to do so will seriously dilute the effect of any additional funds earmarked for the Ombudsprograms. Any appropriation for Title III-D should include the specific provision that funding to the SLTCOP may not be less then the expenditure levels currently in effect in the states.

If the Committee chooses to amend Title III-B, we urge you to increase the base funding to support activities under this section. A reexamination of the base funding in III-B is long over due. Many of the program operation concerns enumerated herein can be incorporated into either the existing section III-B or the New III-D.

In the absence of any new funding, the substantive amendments to the act which will not require additional funds e.g. access to facilities, records, records of state agencies, and immunity should take effect upon completion of the reauthorization. In addition, current language and levels of OAA funding to ombudsman services in the states should be specifically protected.

In conclusion, the status of the Ombudsprograms and the constituencies which we serve has drawn the special interest of concerned members of Congress. The expectations of Ombudsman, consumers, and community advocates have been heightened. We are confident that the reauthorization process will result in substantive improvements in the quality of care provided to consumers and the quality of advocacy on behalf of individual residents.

Senator MATSUNAGA. Thank you.

We would be happy to hear from you now, Ms. Smitherman.

Ms. SMITHERMAN. Good afternoon, Chairman Matsunaga. On behalf of the 55,000 members of the American Dietetic Association, I would like to thank you for the opportunity to address you today on the topic of nutrition services within the reauthorization of the Older Americans Act of 1965. I am pleased that efforts during this reauthorization period are being focused on fine-tuning existing programs and services of the Act.

The potential benefits of nutrition services have been well documented, but there is a need to define the most efficient and effective strategies for delivering a wide range of nutrition services in alternate health care and community settings.

There are several unique characteristics of the older population that must be considered when assessing nutritional status and planning intervention strategies, such as: increased dietary restrictions due to chronic diseases and conditions; decreased ability to utilize essential nutrients, vitamins and minerals; increased use of medications; poor dentition and decreased taste acuity; and other social limitations.

When examining the budgetary needs of Title III meals programs, Congress should take into account inflation, the annual rate of increase in the older population, and the proportion of older individuals at nutritional risk when setting authorization levels and subsequent appropriations levels. Funding for the meals programs in Title III should remain separate from Supportive Services so that the funding for the meals programs will not be diminished in competition with other services.

Registered Dietitians across the nation are observing adverse effects on the older population since the implementation of Medicare's Prospective Payment System. Older Americans are being discharged sicker and quicker, as has been mentioned before, from hospitals and long-term care facilities, greatly increasing the demand for home-delivered meals.

One study conducted by our Association showed that during the first year after the implementation of DRGs, Home-Delivered Meal Programs experienced a 35 to over 50-percent increase in the number of persons receiving meals, with demands exceeding the ability to serve. Dietary restrictions of older adults participating in the program have become more complex, with a greater variety of modified diets needed by participants. Thus, funding for home-delivered meals needs to be increased through direct authorization and appropriation, not through a transfer of funds from the Congregate Meals Program.

Increases in demand for congregate meals has grown faster than increases in funding for the program. Also, the ability to transfer up to 30 percent of funds between Title III programs threatens the number of meals that can be provided. The Program functions not only to deliver a nutritious meal that provides one-third of the Recommended Dietary Allowance to participants, but also serves as a catalyst for involvement in social activities for seniors.

In order to maintain participation in light of budget cuts, congregate meal programs have cut staff to the absolute minimum to maintain the current level of services. Therefore, increased funding is necessary to meet the growing demand.

Inadequate training in food safety and sanitation can cause severe problems. Guidelines and standards on basic food service management skills need to be expanded. The three-fold increase since 1976 in home-delivered meals exacerbates food safety problems inherent in holding hot food too long.

The Congregate Meal Programs are also susceptible to the same problem, and the elderly are particularly at risk when a food-borne illness is contracted. One-half of the meal sites surveyed in the 1981 Elderly Food Systems Delivery Evaluation conducted by HHS had significant sanitation problems.

Nutrition education is a key element in any health promotion/disease prevention program. A mandated nutrition education component to the Act can produce significant cost savings, as evidenced by WIC and Nutrition Education and Training Programs. Similar cost savings could be realized in the Act and in other federal programs such as Medicare and Medicaid. Nutrition education should be mandated as a separate budget line item under Title III–C and required in both the Congregate and Home Delivered Meals Programs.

With the proper allocation of funds, nutrition education and nutritious meals for the elderly will result in positive outcomes and help prevent readmission to institutions.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Smitherman follows:]

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Testimony Presented By

ALICE L. SMITHERMAN, RD
PRESIDENT

OF

THE AMERICAN DIETETIC ASSOCIATION

Before The

SUBCOMMITTEE ON AGING

OF THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

For A Hearing On The

1987 REAUTHORIZATION

OF

THE OLDER AMERICANS ACT OF 1965

430 Senate Dirksen Office Building
2:30 p.m.
April 30, 1987

Statement on the 1987 Reauthorization
Of
The Older Americans Act of 1965
By
The American Dietetic Association

Good Afternoon, Chairman Matsunaga, Senator Cochran, and members of the Subcommittee on Aging.

I am Alice L. Smitherman, President of the American Dietetic Association. On behalf of the 55,000 members of the American Dietetic Association, I would like to thank you for the opportunity to address you today on the topic of nutrition services within the reauthorization of the Older Americans Act of 1965. I am pleased that efforts during this reauthorization period are being focused on fine tuning existing programs and services of the Act.

As the Act has evolved to its present state through successive reauthorizations, nutrition programs for the elderly have grown in significance. The 1972 amendments created the National Nutrition Program for the Elderly, then Title VII. With the 1978 amendments, the nutrition programs were reauthorized and funded under an expanded Title III; specifically, the Title IIIc1 Congregate Meals Program, and the Title IIIc2 Home Delivered Meals Program. The primary objective of Title III is to develop comprehensive and coordinated community-based health and social service systems to foster independent living among older Americans. Thus, Title III meals programs comprise an integral segment of the continuum of care for the elderly.

The continuum of care is intended to provide appropriate health and support services to the elderly, based on their level of dependence and specific health needs. Nutritional well-being is a key component of the health, independence and quality of life of older adults. The potential benefits of nutrition services have been well-documented, but there is a need to define the most efficient and effective strategies for delivering a wide range of nutrition services in alternative health care and community settings. The Older Americans Act is a federal program that does specify nutrition services as a major segment of community-based care.

There are several unique characteristics of the older population that must be considered when assessing nutritional status and planning intervention strategies: increased dietary restrictions due to chronic diseases and conditions such as osteoporosis, atherosclerosis, diabetes, hypertension, and cancer; decreased ability to utilize essential nutrients, vitamins and minerals; increased use of prescription and over-the-counter medications and the potential for drug--nutrient interactions; poor dentition and decreased taste acuity; alterations in psychological and social well-being; limited access to transportation and availability of adequate housing; and limited financial resources, often causing diminished capability to shop and prepare meals.

Title III Meals Programs

When examining the budgetary needs of Title III meals programs, Congress should take into account inflation, the annual rate of increase in the older population, and the proportion of older individuals at nutritional risk when setting authorization levels and subsequent appropriations levels. The older population, although continually increasing in number, will grow at different rates over the next forty years. This segment of the population will experience a dramatic increase with the aging of the "baby boomers." Funding for Title III meals programs in the Act should be separate from Title III Supportive Services, so that the funding for the meals programs, which is inadequate to serve more than one-third of the people who need them, will not be diminished in competition with other support services.

A. Home Delivered Meals

Registered Dietitians across the nation are observing deleterious effects on the older population since the implementation of Medicare's Prospective Payment System. Older Americans are being discharged "sicker and quicker" from hospitals and long term care facilities, greatly increasing the demand for home delivered meals.

One study conducted by our Association showed that during the first year after the implementation of DRG's, home delivered meals programs experienced a 35% to over 50% increase in the number of persons receiving meals, with demand exceeding the ability to serve. Dietary restrictions of older adults participating in the Home Delivered Meals Program have become more complex with the increased demand for meals. A greater variety of modified diets planned by qualified nutrition professionals are now needed by this growing population, adding complexity to increased demand. Thus, funding for the Title IIIc2 Home Delivered Meals Program needs to be increased through direct authorization and appropriation, not through transfer of funds from the Title IIIc1 Congregate Meals Program.

B. Congregate Meals

Increases in demand for congregate meals has also grown faster than increases in funding the Title IIIc1 Congregate Meals Program. Also, the ability to transfer up to 30% of funds between Title III programs threatens the number of meals that can be provided to the elderly. The Congregate Meals Program functions not only to deliver a meal that provides one-third of the Recommended Dietary Allowance to participants, but also serves as a a catalyst for initial and continued involvement by older adults in social activities for seniors.

In order to maintain participation in light of budget cuts, meals programs have cut staff to the absolute minimum to maintain the current level of services. Increased funding is necessary to meet the growing demand for congregate meals and to provide for outreach to maintain and increase program participation by all older adults, especially those with special health and social needs.

C. Food Safety and Sanitation

Inadequate training in food safety and sanitation can cause severe problems. Guidelines and standards need to be expanded within the Act on basic food service management skills for personnel in local agencies. Minimum standards are also needed for food temperature and holding times. The threefold increase since 1976 in home delivered meals exacerbates food safety problems inherent in holding hot food too long.

Congregate meal programs are also susceptible to the same problems. One-half of the congregate meal sites surveyed in 1981 Elderly Food Systems Delivery Evaluation conducted by HHS had significant sanitation problems. The elderly are particularly at risk when a food borne illness is contracted, and food that is marginally safe for consumption can seriously threaten their lives.

Nutrition Education

Nutrition education is a key element in any health promotion/disease prevention program. Education helps ensure that positive life-style changes will be encouraged and it can help decrease the occurrence and/or severity of many chronic diseases. As a result, the older population can experience decreased health care costs, increased independence and improvement in the quality of life.

A mandated nutrition education component to the Act can produce significant cost savings, as evidenced by the Special Supplemental Foods Program for Women, Infants and Children (WIC) and the Nutrition Education and Training Program (NETP). Similar cost savings could be realized in programs within the Act, and in other federal programs such as Medicare and Medicaid. Nutrition education should be mandated as a separate budget line item under Title IIIc, and required in both the Congregate and Home Delivered Meals Programs. A nutrition education component should also exist in Title VII health promotion activities.

With the proper allocation of funds, qualified nutrition professionals can tailor nutrition education programs to meet the special needs of older adults, involve participants, increase nutrition knowledge, and improve food selection. This will result in positive health outcomes and help prevent readmissions to institutions. Nutrition education for the elderly is vital to help them understand, for example, a diabetic meal plan, sodium-restricted diet, drug-nutrient interactions or to combat nutrition misinformation.

Other Programmatic Considerations

Frequent reauthorizations of the Older Americans Act can lead to dramatic changes in the level of services available to the elderly. Therefore, ADA supports increasing the reauthorization period to at least four years.

The Association opposes increasing the percentage of funds that can be transferred within Titles of the Act or the consolidation of programs within the HHS Office of Human Development Services into a block grant. ADA believes the Administration on Aging should have greater autonomy and access to the Secretary of HHS.

Minorities and those with disabilities have specific nutrition and health considerations that the Act must address. The Association supports increased funding for programs targeted to the specific needs of minority and other groups with special needs. With shorter life expectancy and specific health and nutrition needs of special populations, ADA supports decreasing the eligibility age to 55 from 60 years of age to enable those at greater risk to benefit from the meals and other Act programs. In decreasing the age of eligibility, funding must match the size of a larger eligible population and not defer services from older segments of the population.

One of the unique features of the Older Americans Act is the accessibility to programs by all older adults. Half of the older population do not have adequate diets, and a good income does not mean that the older person eats well. ADA opposes income means testing as an eligibility criterion for nutrition services. We feel that this would severely decrease participation in programs within the Act. However, we acknowledge that the aging network should explore more creative means to improve cost sharing options to adequately reflect participants' ability to contribute for services.

I hope that the Subcommittee on Aging will consider the recommendations of the American Dietetic Association for the 1987 reauthorization of the Older Americans Act. The Act provides for, and has historically demonstrated, the opportunity to improve the independence, health and well-being of older Americans. Thank you again for the opportunity to present our views to the Subcommittee.

Senator MATSUNAGA. Thank you, Ms. Smitherman.

We would be happy to hear from you now, Ms. Durham.

Ms. DURHAM. Mr. Chairman, the National Association of Meal Programs is pleased to submit testimony on the reauthorization of the Older Americans Act in its entirety for the record.

I am June Durham, Second Vice President of the Association and Executive Director of the meals program for 18 years. Our Association is one of professionals and volunteers all working to provide nutritious meals to older Americans through both congregate and home-delivered programs.

Our 547 members deliver about 140 million meals a year. Our members' programs are either privately funded or receive assistance from one or more government and private sources. We believe strongly that the Older Americans Act, of course, should be extended.

We also believe that one of the most important—in fact, a focal service supported by the Act is the service of nutritious meals to older Americans. We believe that the trend toward allowing more and more funds under the Act to be transferred between service categories operates to the detriment of the nutrition component of the Act's programs.

The funding for the nutrition component has remained relatively static over the last few years based on per-meal assistance. This situation has created waiting lists for many home-delivered meal programs, in particular, and has placed all programs in a situation where it is very difficult to serve the target population and provide that service to increasing numbers of eligible persons who request and need it.

The role played by the nutrition component of the Act provides a catalyst, the reason for entry into the network of services for older adults. The meals providers are the first and most consistent contact with the target population for linking them with other services and programs of the Act. If we cannot meet their need for meals, the reality is that other services available under the Act may never reach them either.

There are those who have said that the meals component of the Act's programs has not expanded, but still serves the same people serviced ten years ago. This not true. At a recent board meeting of our Association, a survey of the 18 members present indicated that an overwhelming majority were adding eligible recipients as space and funding allowed.

Program providers take their responsibilities very seriously and we see the increased transfer authority as detracting from the program's ability to provide service, since good nutrition has not been given priority by either the Administration on Aging or, in some cases, State and area offices on aging.

Moving more toward increased transfers is the first step, in our view, toward a block grant. The National Association of Meal Programs believes strongly that the losers under such a consolidated program would be those in this target population who need a daily meal to stay healthy and out of the costly health care system.

A good example of this approach to cutting back overall monies under the block grant can be seen in the Administration's budget request this year. No specific program is cut, but the funds for a program block are. We see the block grant approach as squeezing the Older Americans Act little by little until the effectiveness and ability to respond to the needs is impaired irreparably.

We believe that the efforts which have been made toward hospital stay cost containment through DRGs have increased our caseloads tremendously. However, the increased demand for meals, particularly for the homebound who are released from the hospital too soon, has not been funded and the impact on these programs has been tremendous.

Service and food require money and volunteers. The members of our Association all provide home-delivered meals, and 40 percent of them provide congregate meals as well. We average five volunteers for every person served. It can be said that volunteers, in general, provide a myriad of in-kind support and make community programs cost effective.

We appreciate the insights of the Congress and encourage you, Mr. Chairman, and your Committee to see that the meals program needs of those in our nation who cannot help themselves are met.

[The prepared statement of the National Association of Meal Programs follows:]

Statement of the National Association Of Meal Programs

On: Extension Of The Older Americans Act
To: Senate Committee On Labor And Human Resources
Subcommittee On Aging

April 30, 1987

Presented By: Rochelle Berger, Past President

Accompanied by: Michael Giuffrida, Washington Representative

Mr. Chairman, the National Association of Meal Programs is pleased to submit testimony on the reauthorization of the Older Americans Act which expires next year. I am Rochelle Berger, immediate Past President, and currently Chairman of the Legislative Committee of the National Association of Meal Programs, which is an association of professionals and volunteers, all working to provide nutritious meals to older Americans through both congregate and home-delivered meals programs. Our 547 members deliver about 140 million meals a year. Our members' programs are either privately funded or receive assistance from one or more government and private sources.

We believe strongly that the Older Americans Act should be extended. We also believe that one of the most important...in fact, a focal service...supported by the Act is the service of nutritious meals to older Americans, the disabled, frail, or those who are identified as high risk or vulnerable.

We believe that the trend towards allowing more and more funds under the Act to be transferred between service categories operates to the detriment of the nutrition component of the Act's programs. The funding for the nutrition component has remained relatively static over the last few years based on a per meal assistance. This situation has created waiting lists for many home-delivered meal programs in particular, and has placed all our member's programs in a situation where it is very difficult to serve the target population and provide that service to increasing members of eligible persons who request and need it.

We are concerned that the role that the meals component of the program plays in acting as a catalyst for other services is not appreciated or recognized as the reason for entry into network offered services for many older adults. We who provide the meals are the first and most consistent contact which the target population has with the services and programs of the Act. If we cannot meet the designated target population's needs for meals, the reality is that other services available under the Act may never reach those who need them.

There are those who have said that the meals component of the Act's programs have not expanded, but still serve the same people first serviced 10 years ago, except that those people are older. This just could not be further from the truth. At a recent Board meeting of our association, a survey of the 18 members present indicated that an overwhelming majority were adding eligible recipients as space and funding allowed. Program providers take their responsibility to provide service very seriously, and we see the increased transfer authority as detracting from a program's ability to provide service since the good nutrition just has not been given priority by either the

Administration on Aging, or in some cases, state and area offices on aging. Moving more towards increased transfers is the first step, in our view, towards a block grant. The National Association of Meal Programs believes strongly that the losers under such a consolidated program would be those in the target population who need a daily meal to stay healthy and out of the health care system which is so costly. A good example of this approach to cutting back overall monies under the block grant can be seen in the Administration's budget requests this year. No specific program is cut, but the funds for a program block are. We see the block grant approach as squeezing the Older Americans Act programs little by little until their effectiveness and ability to respond to the needs of the target population is irreparably impaired.

We believe that the efforts which have been made towards hospital stay cost containment through the DRG's have increased our various caseloads, and there has been little recognition that the increased demand for meals, particularly for the homebound, does not help make the meals appear. Services and food require money and volunteers to make things happen. The members of the National Association of Meal Programs all provide home-delivered meals and 40% of the membership provide congregate meals as well. We average five volunteers for every meal served. It can be said that volunteers in general, provide a myriad of inkind supports and make community based programs cost-effective.

We encourage the Congress to recognize the importance of nutrition programs in your action on the reauthorization, and also to recognize that the separate entitlement between funding for home-delivered and congregate meals must be retained. The separate entitlements cannot and should not be blended. Congregate meals needs a base of support and the home-delivered meal component needs its financial base as well. The change that should be indicated in this level is an allowance for inflation and an increase in the base funding level because of documented need for services.

Further, the National Association of Meal Programs opposes efforts to reduce levels of funding for other Older Americans Act Programs which additionally contribute towards paying for the meal component and other nutritional services.

With reference to Section 3(d) which refers to In-Home Services to Frail Older Individuals, the National Association of Meal Programs is supportive of this new initiative and encourages the enactment of a broad appropriation. As people age chronologically, the need for additional services is tantamount to avoiding costly premature institutionalization. In-home services, as defined in Section 344, finally recognizes the need for expanded services already defined by service providers across the country, as requested by recipients of meal programs.

Mr. Chairman, older Americans of our nation, the disabled, the frail, the vulnerable, need the nutrition services provided by meals programs. Our programs provide the outreach which binds together the continuum of services for these groups. We are opposed to a means for these nutrition services, however, we support efforts to target our services to those who need it most.

To require cost sharing for services provided through the Older Americans Act would precipitate a means test which, to reiterate, the National Association of Meal Programs opposes. We urge the Congress to recognize these concerns in your actions on the reauthorization of the Act.

Senator MATSUNAGA. Thank you very much, Ms. Durham.

Mr. Pickering, I am curious to know, as a lawyer myself, how you arrived at that six-percent figure as the minimum for legal services.

Mr. PICKERING. That was what we found the average area agency on aging spent for legal services in fiscal year 1980, the last time that statistics were kept.

Senator MATSUNAGA. I see.

Mr. PICKERING. As we point out in our statement, Congress found in 1975 that some of the State agencies were not spending money for some of the more critical services. There was a scattergun of services that was going on, so Congress, in effect, mandated that some funds be spent on three priority areas and then hit on the idea of an adequate level of funding.

Six percent, as I indicated earlier, is not a magic number. We simply picked it out on the basis of experience, and we urge that something more than the adequate proportion language be used because we find that about 15 percent of the AAAs are not spending anything on legal services.

We also find that the need for those services is growing, as are cutbacks in domestic programs of various sorts, as funding either has been reduced or has stayed the same, despite the fact of increased needs and as various programs have been undertaken to do this, that or the other.

That is the reason we also emphasize the need for a private right of action simply in order to make certain that the legislation as passed by Congress is faithfully carried out.

Senator MATSUNAGA. Thank you very much.

Now, Ms. Crittenden, I think one of the most successful programs for the elderly has been the establishment of senior centers. I have visited many of them in Hawaii and I have seen elderly friends of mine who used to just stay home and just literally rock in the chair on the porch, taking up art crafts and learning to play the ukulele, learning to dance the hula, and even getting married at age 70, 75, after having been widowed for 15, 20 years.

I can see the difference from when they used to just stay at home. When they started participating in activities at these senior centers, they seemed to just grow young again.

I am curious to know just how many senior centers are there in the United States.

Ms. CRITTENDEN. You are not the only one curious to know that, Senator. I do not believe there is anyone who is certain of that fact.

Senator MATSUNAGA. But every State today has senior centers?

Ms. CRITTENDEN. Oh, yes, sir. I think we would be looking probably at somewhere between—a rough guess here—7,000 and 10,000 senior centers in the nation, serving close to nine million people, a lot of folks.

Senator MATSUNAGA. I think that has been one of the best things that has happened. As one of the original cosponsors of the Older Americans Act of 1965, I am truly gratified.

Ms. CRITTENDEN. Thank you.

Senator MATSUNAGA. Now, Ms. Duson, the Administration has proposed that the reauthorization legislation include a provision that would require a 15-percent match of federal funds for the long-term care ombudsman program.

What would be the effect of such a requirement on such programs?

Ms. DUSON. I think that currently—I would have to go back and check some records, but I think that most States do contribute some modest amount of State funding to the long-term care ombudsman program.

However, I think that my response would be that we think it important for the basic four requirements of the program and the requirement that there be one warm body to make sure they are carried out be something that remains within the discretion of the State unit on aging under the auspices of the Older Americans Act, so that there can be some standardization of quality from one State to the other, that being the complaint handling process, the consumer education, and volunteer involvement issues.

It is very important for those to be clearly structured within the Act and maintained in some standardized manner across States. In my own State, State funding to the program in Maine represents, I think, at this point about 60 percent of the State ombudsman program budget.

However, it is the federal funding that sets the tone for what the program does. We write a grant to the State unit and the State unit evaluates whether we are carrying out the operations of the program using both our State and federal dollars.

Senator MATSUNAGA. Thank you very much.

Now, Ms. Smitherman, what effect will mandatory cost sharing have on the participation or targeting to those most in need?

Ms. SMITHERMAN. I do not have the specific figures today, Mr. Chairman. I would be happy to submit those for the record.

Senator MATSUNAGA. Thank you.

Ms. SMITHERMAN. I think it is very clear that it would create a burden, a serious burden.

Senator MATSUNAGA. Of course, I was referring to the congregate nutrition program.

Ms. SMITHERMAN. Yes.

Senator MATSUNAGA. We would appreciate your response in writing for the record, if you will.

Ms. SMITHERMAN. Yes, we will, Mr. Chairman.

[Response of Ms. Smitherman to question asked by Senator Matsunaga follows:]

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May 28, 1987

The Honorable Spark M. Matsunaga
United States Senate
109 Hart Senate Office Building
Washington, DC 20510

Dear Senator Matsunaga:

I want to thank you again for the opportunity to testify on behalf of The American Dietetic Association at the April 30 hearing of the Subcommittee on Aging of the Senate Labor and Human Resources Committee. The testimony provided by the Association and other groups provides a basis for the improvement and fine tuning of existing programs within the Older Americans Act.

At the hearing you posed a question on the effect of an income means test on participation in the Title III Congregate and Home Delivered Meals Programs. Unfortunately, without a requirement for income means testing in Older Americans Act programs, there is little numerical data available to demonstrate how elderly individuals would be affected by a test. Therefore, we must rely on anecdotal data from Act programs and the effect of an income means test on participation in other social programs. In order to thoroughly assess the impact of a means test, we must first determine what segments of the older population, if any, are not participating under the current system.

With current funding unable to meet the demand for services in the Congregate and Home Delivered Meals Programs, outreach to priority groups (low-income and minorities) has been virtually eliminated and many programs throughout the nation have waiting lists for participants. Increased efforts to recoup costs through voluntary contributions often cause low-income and minority elderly to drop out of programs, stigmatized by the inability to pay in a setting where middle-income participants are making contributions. These factors clearly indicate that, under the present system, programs could greatly improve recruitment and retention efforts.

Independence is important to the elderly. As seen with means testing in other social programs, some current participants would drop out because of pride and the stigma associated with the administration of a means test, independent of eligibility. Some social programs that have converted to an income means test have experienced up to a 50% decrease in participants (e.g., Title XX programs). Also, without knowing what income level would be used to establish eligibility (e.g., 125%, 185%, or 200% of the poverty level), we cannot accurately determine the numeric impact of a means test. A means test does not address social and physical limitations that effect nutrition and health status of the elderly, such as: access to food (other than economic), minority status, transportation, social isolation, frail old age, chronic health problems, lack of family support, and inability to get out of the house due to physical disabilities or neighborhood safety concerns. Also, nutrition services provided under the Act are, in many cases, a cost-effective means of keeping older individuals out of hospitals and nursing homes regardless of income.

While opposed to an income means test, the Association believes that there are other creative funding mechanisms that may be more effective than a means test for optimizing utilization of resources and participation. For example, a sliding fee scale could be implemented with an appropriate income cut-off to maintain fully subsidized services in current priority groups. Those from income levels above the cut-off would then make contributions appropriate to their income. Older adults could then be treated equitably in coordination with sliding fee schedules utilized in other state and community based social service programs. In the absence of stigma associated with a means test as a "welfare program" or "inability to contribute my fair share," participation could be maintained and/or increased and revenue generated could be used to improve outreach to priority groups.

Impact data on cost recovery mechanisms needs to be collected through small experimental local projects before widespread implementation in urban, suburban, and rural delivery settings. All organizations involved with the delivery of services to the elderly should be involved in the development/writing of the proposal for an experimental project. Analysis of data collected by such projects could then be used in forging new cost recovery policy in the Older Americans Act.

The need to further explore funding mechanisms before making changes in eligibility policy in the Act is underscored by the lack of data available and the many factors beyond income that effect the health and well-being of the elderly. Testimony before the Subcommittee on the 1987 reauthorization of the Act and specifically your inquiry has stimulated the need to investigate the question of a means test. The American Dietetic Association encourages consideration of the need for further investigation and small experimental projects coordinated by Congress and the aging service community.

Sincerely,

Alice Smitherman

Alice Smitherman, RD
President

AS/be

Senator MATSUNAGA. Ms. Durham, I think the most obvious, most noted part of the Older Americans Act has been the nutrition program, the meals programs. In Hawaii, of course, we have no problems of snow and senior citizens have no fear of missing a meal because the delivery people can always get to them. Those who are confined to their residences, for example, always get their meals.

Having been here now on the Hill for 25 years, so often I hear on the radio that meals for senior citizens will not be served today. Now, what happens? We had four days of snowbound people in the last big snow that we had. What happens to the senior citizens?

Ms. DURHAM. Of course, I am like you, Senator Matsunaga; I am from South Carolina and we have about two days of snow. I am amazed at the ingenuity which is used by our members in the national association.

In all cases that I know of, shelf staple foods are provided for them to use during these weather meals when the hot meals cannot reach them. So they are provided for on those days.

Senator MATSUNAGA. Do you think we should provide in the law or by regulation that shelf food be provided?

Ms. DURHAM. I think that is a good idea. It would certainly help to fund those meals, which are more expensive than our regular services.

Senator MATSUNAGA. I have heard some complaints from senior citizens that they were without food for two, three days. Maybe they do not have shelf foods, as some of the agencies do provide. Well, it is a thought, anyhow.

Well, thank you all for taking time out of your busy day and coming from distances to be with us. Definitely, your suggestions will be taken very seriously by the Subcommittee.

Our next panel of witnesses represents the research and training community in the field of gerontology under Title IV. We would be happy to hear now from Mr. John Cornman, who is the Executive Director of the Gerontological Society of America, and Dr. Richard W. Lindsay, President of the American Geriatrics Society.

Mr. Cornman, we would be happy to hear from you.

STATEMENTS OF JOHN M. CORNMAN, EXECUTIVE DIRECTOR, GERONTOLOGICAL SOCIETY OF AMERICA, WASHINGTON, DC; AND RICHARD W. LINDSAY, PRESIDENT, AMERICAN GERIATRICS SOCIETY, CHARLOTTESVILLE, VA

Mr. CORNMAN. Thank you. Mr. Chairman, since my remarks will be somewhat critical of the Administration's performance in carrying out certain parts of the Title IV program, I would like to begin by acknowledging that the Administration on Aging has been a strong supporter of the Society's Fellowship Program in Applied Gerontology, which is a very effective mechanism for delivering expert technical assistance to service delivery agencies.

It is also a marvelous example of a private-public cooperation where we get up to three dollars of private money for each dollar of federal money. I wanted to put that on the record to acknowledge that they have been cooperative before I start my comments.

Title IV, as amended in 1984, provides a well organized and coordinated framework for the activities authorized under that title. The Society's concern, therefore, is not with the statutory language, but rather with the fact that the Administration has disregarded much of that language in setting its funding priorities.

At a 1985 workshop convened by the Administration on Aging, participants reaffirmed that the OAA training grant program was "one of the best, if not the only means available to the Commissioner on Aging to advance new ideas and approaches both within the federal government in the field of training and education in aging, but also within the aging network of the Older Americans Act."

While we were encouraged by this attempt to establish a direction for the education and training program of OAA, less than two years later the Administration attempted to divert one-half of the Title IV fiscal 1987 funds to foster care activities and to pay for federal salary increases. This rechanneling of funds was rejected by Congress, but the funds have not yet been restored to this program.

Similarly, in fiscal 1985, less than $500,000 of Title IV funds went for research—hardly what you would call a major commitment to research. In 1981, the figure was $3.6 million.

These kinds of actions are puzzling in light of the following facts. First, Title IV is the principal source of federal support for research and demonstration projects to determine the needs for and to test non-medical service delivery programs for the elderly.

Two, the minority participation rate in OAA programs dropped from an already low 19 percent in fiscal 1980 to 16 percent in 1985. We do not know why this drop occurred, and therefore we do not know how to best address that problem.

Third, Title IV is the principal source of federal support for the education of service delivery trainers and practitioners in aging, and we are only going to be able to improve the quality of service delivery by improving the quality of the service deliverer.

It is clear, therefore, that the answers on how to provide the needed facilities and services within the available resources will be found only through, one, research to determine needs among the elderly and to develop models for responding to those needs; two, through demonstration projects to test new concepts and models; three, through dissemination of new knowledge; and, four, through creation of a well-trained cadre of service deliverers.

Based on those concerns, we have four or five modest recommendations. They are, one, that all Older Americans Act programs should be extended for at least three years, and probably longer.

Two, funding for all titles of the Older Americans Act, including Title IV, should be increased by at least five percent to meet the growing demand for services, programs and research. That five percent is probably too low a figure, but given the problems of Gramm-Rudman, we are trying to be realistic on that one.

Three, we should retain the current allocation formula for Title III programs and not move to the Administration's recommendation to up the eligibility age to 70.

Four, we oppose consolidation of Title IV programs. The goals and the organizations of Title IV, should be retained as stated. We do think, though, that within Title IV that the Congress should create line-item authorizations for the three major activities in the title, which are education and training, research, and demonstration programs. This will allow both Congress and other people to trace and monitor better the amount of money going for these activities.

Five, the Administration has required virtually every grant under its 1986 discretionary research and development program to have a letter of support from a State unit or area agency on aging, whether or not it was appropriate. This requirement should not be put in force across the board.

Finally, we think that there should be an additional statement added to Section 410 of the Act, and this statement would provide a special emphasis on education and training programs for minorities and on research on minority elderly needs and participation in OAA programs.

Thank you very much.

[The prepared statement of Mr. Cornman follows:]

The Gerontological Society of America
RESEARCH, PRACTICE AND EDUCATION IN AGING
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STATEMENT

OF

JOHN M. CORNMAN
Executive Director
The Gerontological Society of America

PRESENTED TO

SUBCOMMITTEE ON AGING

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ADDRESSING

1987 REAUTHORIZATION OF THE OLDER AMERICANS ACT, TITLE IV

April 30, 1987
2:30 p.m.

Mr. Chairman, I am John Cornman, Executive Director of The Gerontological Society of America. The Society welcomes the opportunity to present its views on reauthorization of the Older Americans Act, specifically with regard to Title IV.

Let me begin by commenting briefly on the significant changes Congress made in Title IV in the 1984 reauthorization of the Older Americans Act, changes which have greatly improved the title's organization and potential impact. Congress added a statement of purpose which specified the four areas addressed by the title: education and training of personnel to work with and on behalf of older individuals; research and development of effective practices in the field of aging; demonstration projects directly related to the field of aging; and dissemination of information on aging and the aging process.

The 1984 reauthorization also added statements of purpose for Part A, Education and Training, and for Part B, Research, Demonstrations, and Other Activities. Specific goals to be obtained within three years also were delineated. These changes made it possible to design and evaluate an overall program in which the various activities authorized by the title are related.

Title IV, as amended in 1984, provides a well-organized and coordinated framework for activities authorized. The Gerontological Society's concern, therefore, is not with the statutory language, but rather with the fact that the Administration on Aging has totally disregarded this language in setting its funding priorities.

At a 1985 workshop sponsored by AoA, participants reaffirmed that the OAA training grant program was "one of the best, if not possibly the only, means available to the Commissioner on Aging to advance new ideas and approaches both within the federal government in the field of training and education in aging but also within the 'aging network' of the Older Americans Act." Participants further outlined strategies to best achieve these goals.

While we were encouraged by this attempt to establish a direction for the education and training program, less than two years later the administration attempted to divert one-half of the Title IV FY 1987 funds to foster care activities and to pay for federal salary increases. This rechanneling of funds was rejected by Congress, but the funds, as yet, have not been fully restored to the Title IV program.

A research program with an annual budget of less than $500,000 indicates a lack of commitment to research under the Older Americans Act. The administration's proposed new allocation formula for states to receive OAA funds, based on the number of individuals over 70, provides further evidence of disregard for research findings in making major policy decisions. Even a quick review of the literature tells us that people age differently and that minority elderly are likely to need services at younger ages, and, in fact, are less likely to survive to age 70 than their white counterparts.

The administration's actions are puzzling in light of the facts that

* Title IV is the principal source of federal support for research and demonstration projects to determine the need for and to test non-medical service delivery programs for the elderly;
* The minority participation rate in OAA programs dropped from 19

percent in FY 1980 to 16.4 percent in 1985 and we do not know why or how to best address the problem;

- Title IV is the principal source of federal support for the education of service delivery trainers and practitioners in aging; and
- In the years that federal appropriations for Title IV have fallen 59 percent, from a high of $54.3 million to a low of $22.2 million (the largest decline for any OAA program), the elderly population has been growing steadily with a corresponding increase in need for flexible housing arrangements, in-home services, and health maintenance programs which can help extend independence and delay costly institutionalization.

It is clear that the answers of how to provide the needed facilities and services within the available resources will be found through (1) research to determine needs among the elderly and developing models for responding to those needs; (2) demonstration projects to test new concepts and models; (3) dissemination of new knowledge; and (4) through creation of a well-trained cadre of service deliverers.

The Gerontological Society's Fellowship Program in Applied Gerontology illustrates how dependent aging programs are on good research. Now in its fourteenth year, the program has successfully demonstrated that more appropriate policy and program decisions can be made when based on applied research. Research is the mechanism which could and should be used to guide service planning and delivery and policy development. Linking the expertise of gerontologists with agencies to address specific problems has led to many beneficial outcomes. A few examples follow:

- Information routinely gathered on more than 1,000 clients was underutilized by the East Arkansas Area Agency on Aging because of limited data analysis capabilities. A 1981 FPAG fellow used the data to provide a profile and needs assessment of elderly persons in the area which proved valuable in allocating resources and in planning for future services.
- In 1982, fellows assigned to Hurley Medical Center in Flint, Michigan, used medical geography techniques to determine which services were most wanted and used by area elders. This information was used in planning future clinics.
- A 1981 fellow for the House Select Committee on Aging evaluated legislative alternatives with regard to mandatory retirement issues for police workers and firefighters. The study findings are still being used to ensure adequate enforcement of several federal statutes.
- A 1983 fellow developed evaluation strategies and instruments for the adult day care staff of Parkside Human Services Corporation, in Park Ridge, Illinois, which provided for the first time an objective sense of whether individual care plans for clients were bringing about desired physical and psychosocial results.

The value of these collaborative efforts is reflected in the fact that two-thirds of the fellows continued to work with their host agency in some capacity beyond the project period.

Recommendations

The Gerontological Society of America urges this subcommittee to maintain close oversight of the activities carried out under the Title IV program to ensure that they address the goals and objectives as stated in the Act. In addition, the Society offers the following recommendations:

* **At least a three-year extension.** All Older Americans Act programs should be extended for at least three years, through 1990, with the possibility of a longer extension.
* **Increased authorization levels.** Funding for all titles of the Older Americans Act, including Title IV, should be increased by at least 5 percent to meet the growing demand for services, programs, and research authorized under this Act and the increasing cost of implementing these programs.
* **Retain current allocation formula for Title III.** The formula used to determine allocations for Title III should continue to be based on the population aged 60 plus and not be changed, as proposed by the Administration's proposal to use a formula based on the population aged 70 plus.
* **Oppose consolidation of Title IV program.** The goals and organiation of Title IV should be retained with only minor modifications, if necessary.
* **Establish line-item authorization within Title IV.** Line-item authorizations should be established for the three major activities within this title: (1) education and training; (2) research; and (3) demonstrations and other activities.

- **Oppose requirement for SUA or AAA approval on all discretionary program grants.** Virtually every grant under 1986 discretionary program announcement required grantees to have a letter of support from a state unit or area agency on aging, whether or not it was appropriate. This practice should be continued only when appropriate.
- **Promotion of career preparation training for minorities.** Section 410 of the Act should be amended to add a sixth purpose. That purpose would be "providing special emphasis on education and training programs for minorities." This emphasis is needed to attract more minorities into the field of aging.

Senator MATSUNAGA. Thank you very much, Mr. Cornman.

We will be happy to hear from you now, Dr. Lindsay.

Dr. LINDSAY. Thank you, Mr. Chairman, for the privilege of appearing before you this afternoon. I am Dr. Richard W. Lindsay, Professor of Internal Medicine and Director of the Division of Geriatrics at the University of Virginia School of Medicine. I am here today representing the American Geriatrics Society as its President.

I am pleased to have been asked to comment on the need for training and research under the Older Americans Act. This Act has obviously increased public awareness of the special needs of the elderly, while concomitantly improving the quality of life for our older population.

We endorse the multidisciplinary approach advocated under the Act, recognizing the wide spectrum of medical and social needs of the elderly. I will focus my testimony on Title IV of the Act, particularly relating it to some primary objectives of the American Geriatrics Society.

Two primary objectives of the AGS include educational training and research efforts. Through the Society's committee structure, we develop programs and publications to keep physicians and allied health professionals informed of basic and clinical research advances in this field.

We believe there exists a definable and growing body of scientific knowledge and new skills that are necessary for competence in the medical care of the elderly. The American Geriatrics Society has developed curriculum guidelines for geriatric fellowship training programs. These guidelines have been reviewed by the Residency Review Committees in both internal medicine and family practice.

Our recommendations will provide direction for instituting training programs for future internists and family physicians. In our guidelines we state the following.

Working relationships with other medical disciplines will be required for an effective, integrated program. These include, notably, psychology, neurology, physical medicine, and rehabilitation, as well as dermatology and subspeciality surgery, especially orthopedics, ophthalmology, otorhinolaryngology, including audiology, urology, and gynecology.

Additional departments should also be involved, nursing and social work being essential. Optimally, these should include nutrition, clinical psychology, occupational medicine, dentistry, pharmacy, podiatry, and pastoral care.

The range of facilities and resources necessary for fellowship training must reflect a health care system appropriate for the care of the full spectrum of elderly individuals, extending from those persons who are well and require only routine and preventive health care, to those who are frail and require a full range of medical and social services.

The facilities required include all levels of acute hospital care, one or more levels of chronic institutional care, and one or more varieties of chronic, non-institutional care such as home care and day care. These tenets will be incorporated in the geriatric training programs of our medical schools.

In addition, we recognize the urgency of identifying the manpower needs within geriatrics. We participated in an Institute of Medicine national conference that focused on this very question. We concur with the general conclusion of this meeting.

We shall need centers of excellence in which to train persons who, in turn, will be able to educate future generations of geriatricians. The time is short and the need great.

The final Institute of Medicine report will be published in the August issue of our peer review journal, the *Journal of the American Geriatrics Society*. Both the *Journal* and the series of position statements developed by the Society address many of the directives encompassed in the Older Americans Act.

Scanning a list of articles included in the *Journal* will lend insight into our effort to provide clinicians and allied health professionals important and wide-ranging information from today's experts.

The AGS position statements identify research areas that need further investigation and pay special attention to the specific social and medical considerations for which the elderly are at most risk. The complete text of these statements have been submitted for the record.

As evidenced by our own initiatives, we strongly endorse the reallocation of funds for the 1987 Older Americans Act. A carefully planned agenda for the elderly must be a primary concern for all Americans.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Lindsay, with attachment, follows:]

Mr. Chairman and members of the Subcommittee:

My name is Dr. Richard W. Lindsay, Professor of Internal Medicine and Director of the Division of Geriatrics at the University of Virginia Medical School. I am here today representing the American Geriatrics Society of which I am President.

The American Geriatrics Society, founded in 1942, is dedicated to improving the quality of life for the aging and aged population with particular emphasis on the dissemination of geriatric medical education and the future delivery of geriatric medical care. The 5,500 members of the society include a broad representation of clinicians, researchers, and educators, in internal medicine, family medicine, and psychiatry. Our primary goal is to improve the care of the elderly through research, education, and innovation in clinical practice.

I am pleased to be asked to comment on the need for changes in training and research under the Older Americans Act. This Act has obviously increased public awareness of the special needs of the elderly, while concomitantly improving the quality of life for our older population. We endorse the multidisciplinary approach advocated under the Act, recognizing the spectrum of medical and social needs of the elderly.

The changing demographics of our society, with the maturation of the "baby boom" generation, will swell the ranks of our elderly population. America is aging and the important concepts included in the Older Americans Act will remain an important focus for the general population and legislators.

I was asked to focus my testimony on Title IV of the Act - "Training, Research, and Discretionary Projects and Programs." Two primary objectives of the American Geriatrics Society include educational training and research efforts. Through the Society's committee structure, we develop programs and publications to keep physicians and allied health professionals informed of basic and clinical research advances in the field. We believe there exists a definable and growing body of scientific knowledge and new skills that are necessary for competence in the medical care of the elderly.

The American Geriatrics Society developed curriculum guidelines for geriatrics fellowship training programs. These guidelines have been reviewed by the Residency Review Committees in both internal medicine and family practice. Our recommendations will provide direction for instituting training programs for future internists and family physicians. We state in our guidelines:

> "Working relationships with other medical disciplines will be required for an effective, integrated program. These include notably psychiatry, neurology, and physical medicine and rehabilitation, as well as general dermatology and subspecialty surgery (especially orthopedics, ophthalmology, otorhinolaryngology, including audiology, urology, and gynecology). Additional departments should also be involved, with nursing and social work being essential. Optimally, these should include nutrition, clinical psychology, occupational medicine, dentistry, pharmacy, podiatry, and pastoral care."
>
> "The range of facilities and resources necessary for fellowship training must reflect a health care system appropriate for the care of the full spectrum of elderly individuals, extending from those persons who are well and require only routine and preventive health care to those who are frail and require a full range of medical and social services. The facilities required include all levels of acute hospital care, one or more levels of chronic institutional care, and one or more varieties of chronic non-institutional care, such as home care and day care."

These tenets will become incorporated in the geriatrics training programs in our medical schools.

In addition, we recognize the urgency of identifying the manpower needs within geriatrics. We participated in an Institute of Medicine national conference that focussed on this very question. We concur with the general conclusion of this meeting; we shall need centers of excellence in which to train persons who in turn will be able to educate future generations of geriatricians. The time is short and the need great. The final Institute of Medicine report will be published in the August issue of our peer review Journal of the American Geriatrics Society.

Both the Journal and a series of position statements developed by the Society, address many of the directives encompassed in the Older Americans Act. Scanning the list of articles included in the Journal will lend insight into our efforts to provide clinicians and allied health professionals important and wide-ranging information from today's experts. The AGS Position Statements identify research areas that need further investigation and pay special attention to specific social and medical considerations where the elderly may be at most risk. The complete texts of these statements have been submitted for the record.

As evidenced by our own initiatives, we strongly endorse the reallocation of funds for the 1987 Older Americans Act. A carefully planned agenda for the elderly must be a primary concern to all Americans.

Thank you.

THE AMERICAN GERIATRICS SOCIETY
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Linda Hiddemen Barondess
Executive Vice President

AMERICAN GERIATRICS SOCIETY

POSTION STATEMENTS

Attached are position statements approved by the Board of Directors of the American Geriatrics Society. A complete list of position statements, including those currently being developed by the AGS Public Policy Committee, may be obtained by contacting the headquarters office:

770 Lexington Avenue
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AGS POSITION STATEMENT ON EDUCATION IN GERIATRIC MEDICINE

(EDITOR'S NOTE: This Public Policy Committee-sponsored statement was the basis for a Mailgram sent to members of Congress objecting to the proposed discontinuance of Medicare support for graduate medical education beyond the period required for initial board certification.)

Background

The elderly represent a growing proportion of our population. Because of an extended lifetime of exposure to disease, a significant proportion of the elderly require acute and chronic medical care.

There exists a definable and growing body of scientific knowledge and new skills that is necessary for competence in the medical care of the elderly. Despite this, there are professional and societal barriers which have slowed the progress of enriching medical education at all levels with materials concerning geriatrics and gerontology.

The AGS, which has broad representation by clinicians, researchers, and educators in the area of geriatric medicine, should serve as an advisory body in determining the requirements for such education and for the formal recognition of those with special competency in geriatrics.

Positions

1. Geriatric medicine should be a required part of the curriculum in each year of medical school.

2. Graduate education (residency) programs such as those in psychiatry, internal medicine, and family practice should also be required to have clinical and didactic experience in geriatric medicine.

3. Significant increases in funding are needed to expand education in geriatric medicine and most especially the development and maintenance of physicians on medical school faculties who have special knowledge and expertise in geriatrics. Faculty and clinical specialists in geriatric medicine should have specific geriatric training beyond the level required for initial certification in specialty areas such as internal medicine, family medicine, or psychiatry.

4. Given the relationship between education and improved patient care, and the large proportion of elderly served by these programs, the Veterans Administration and Medicare have a special role for the support and development of educational programs in geriatric medicine.

5. Formal recognition is needed for physicians with advanced knowledge and skills in aging and in medical care of older persons. This recognition should be provided by any specialty that encompasses a significant body of knowledge and clinical practice related to elderly persons.

AGS POSITION STATEMENT ON NURSING HOME REGULATION RELATED TO MEDICAL CARE

(EDITOR'S NOTE: This position paper was developed by the Public Policy Committee and approved by the AGS Board of Directors in July 1985. This, like all other Society position statements, is in constant evolution. We invite readers to send their comments and suggestions for revisions.)

Background

The need for nursing home regulation arose from well-documented and deplorable instances of poor patient care in some nursing homes. In efforts to protect patients, a large number and variety of regulations at the state, federal, and local level have been developed concerning all areas of care in the nursing home, including medical care. The aim of such regulation of medical care appears to be to improve and enhance the outcome of medical care in nursing homes.

While some of the regulations have resulted in significant improvement in the standard of medical care, others have been contradictory and unclear or have limited innovation and discouraged physician participation in the nursing home. The present regulatory process is inefficient and ineffective because of the involvement of multiple agencies in an uncoordinated fashion. In far too many instances, expediency has dictated the use of paper reviews or structural or process measures rather than a focus on assessing the outcome of medical care in nursing home patients. Physicians and other nursing home professionals thus often spend significant amounts of time in redundant tasks to insure paper compliance with regulation rather than focusing on direct patient care.

Positions

1. While public regulation of medical care in nursing homes has a definite role in insuring an adequate standard of care, many current regulations and regulating processes are counterproductive.

2. Major improvements are needed in the level of coordination among various regulating agencies, between different sets of regulations, and between regulating agencies and reimbursement policy makers.

3. The goal of regulation should be to help insure a high standard of care in nursing homes. To develop better standards in this regard, research to define more appropriate measures of the quality of care in nursing homes is needed. Especially important are studies which can provide information relating outcome and cost and studies that identify optimal patterns of drug, laboratory, physician, and hospital utilization by nursing home residents.

4. Regulations related to medical care should require peer review mechanisms such as medical staff credentialling and formal medical staff quality assurance programs.

5. Regulations regarding medical care should require that active efforts are made to insure the involvement of nursing home residents or their guardians or families in medical care decisions and in quality of care assessments.

6. The standard of medical care practice in nursing homes should be based on national standards. The accreditation standards developed by the Joint Commission on Accreditation of Hospitals is a positive step towards insuring a high, nationally recognized standard of care in nursing homes. Federal, state, and local regulations should be revised where appropriate to reflect a similar standard of care.

7. Regulation alone is not sufficient to insure an adequate quality of medical care in nursing homes. Other means such as education in geriatric medicine and equitable reimbursement for medical services in nursing homes are equally important.

AGS POSITION STATEMENT ON CONVERSION OF PRESCRIPTION DRUGS TO OVER-THE-COUNTER DESIGNATION

(This position paper was developed by the Public Policy Committee and approved by the AGS Board of Directors in March 1986. This, like all Society position statements, is in constant evolution. We invite readers to send their comments and suggestions for revisions.)

Background Elderly individuals consume large quantities of over-the-counter drugs, especially pain relievers and sedatives. Conversion of additional drugs to over-the-counter status carries with it a number of potential risks of particular importance to the elderly, including:

1. Overdosage due to self-prescription of doses and frequencies of administration.
2. Adverse reactions due to pharmacologic actions, drug hypersensitivity, or inappropriate drug combinations.
3. Inadvertent polypharmacy due to self-prescription or the presence of multiple drugs within over-the-counter preparations.
4. Increased costs due to self-prescription.
5. Inadequate drug information and warnings concerning side effects, contraindications, and drug interactions.
6. Package inserts that are difficult to read because of small type size or are difficult to understand because of technical language used.

Positions

1. The Food and Drug Administration (FDA) should require understandable and readable (large print) labels on all over-the-counter drugs.
2. Before a drug is released as an over-the-counter drug, age-specific complications should be carefully reviewed, together with projections of possible effects of increased drug use after conversion based on data obtained from previous conversion of similar drugs to over-the-counter status.
3. Follow-up studies on altered patterns of drug use by age category (including rates of drug side effects noted) resulting from the conversion of prescription to an over-the-counter drug should be mandated. These studies should be financed by over-the-counter drug manufacturers, but evaluated by the FDA.
4. The conversion of prescription to over-the-counter drugs should occur only when there is a significant net cost savings to the consumer and, when appropriate, studies on safety and efficacy of the conversion outlined above have been completed.

AGS POSITION STATEMENT ON RESEARCH AND GERIATRIC MEDICINE

(This position paper was developed by the Public Policy Committee and approved by the Board of Directors in March 1986. We invite readers to send us their comments and suggestions for revisions.)

Background

The elderly represent an increasing proportion of our population and require a major proportion of acute and chronic medical care delivered in this country. Gerontological research has begun to provide a base of scientific knowledge which is needed to aid physicians and other health care professionals providing appropriate care for the elderly population. Such care includes the treatment of psychological, biological, and socially related problems of the elderly with the aim of preventing disease and disability and of enhancing well-being whenever possible. Research in the field is still in a developmental state, and many gaps in our knowledge remain. Research in geriatric medicine covers a broad area and overlaps considerably with inquiries into social gerontology, biology, clinical medicine, psychology, health care delivery, health promotion and disease prevention, and technology assessment.

The membership of the American Geriatrics Society includes a broad representation of clinicians, researchers, and educators in the field of geriatric medicine. Given this membership and their potential for significant interaction with researchers in other areas of medicine and health care and its close linkage with the American Federation for Aging Research, the AGS can, and should, serve as one mechanism for focusing attention on the specific areas of research required to improve the health of our elderly citizens.

Positions

A. Research Training

1. Training in specific research methodologies must be included in research fellowship training programs in geriatric medicine. Because of the wide range of appropriate and important areas of inquiry, the specific content area may vary. However, in many circumstances the training should include biostatistics and clinical epidemiology, decision analysis, and critical evaluation of published literature in addition to the more traditional laboratory oriented methodologies as applicable to the biological sciences.

2. Research in geriatric medicine should be encouraged as a significant and highly important area of endeavor by medical schools, nursing schools, schools of public health, and other appropriate professional schools. Chairpersons of departments and other appropriate high level administrative officers should be encouraged to promote research in geriatric medicine as an

important feature of their program and to indicate that successful endeavors in this area will be rewarded appropriately, as a stimulus to investigate work.

B. Scope of Research

In order to further the goal of maximizing the health status of our older Americans, research should include and be strongly encouraged especially in the following areas:

1. Basic biology of the aging process--studies of the molecular, cellular, and physiologic aspects of aging may help answer many questions relating not only to the aging process but to many of the diseases of aging, which share in part of this psychological decrement.

2. Basic and clinical research in the diseases of major importance in aging (e.g., cardiovascular disease, cerebral vascular disease, cancer, arthritis, Alzheimer's disease, etc.). In this context, certain specific areas of inquiry are appropriate.

    a. Research into disease etiology and characteristics as they are manifested in elderly individuals compared with manifestations in the young.

    b. Research into variations in approach to diagnosis and treatment mandated by older age.

    c. Research into prevention of disease and/or complications in the elderly.

3. Basic and clinical research in problems creating major functional disability in the elderly (e.g., falls, incontinence, osteoporosis, orthostatic hypotension, and memory loss).

4. Clinical research on the approach to the elderly patient and how it differs from that to the younger patient (e.g., hospital management, consultation services, multidisciplinary needs, clinical pharmacological alterations, clinical assessment, technology utilization, etc.).

5. Research into the most effective methods for the delivery of health care for problems of the elderly (e.g., home services, geriatric assessment units, outpatient care, respite care, day care, nursing home care, development of new and innovative methods for so doing).

6. Research on health promotion and disease prevention for elderly individuals. This will of necessity overlap with efforts in younger Americans, but it is entirely appropriate given the overall goals of such research in establishing a factual basis for the use of, or recommendation for, preventative modalities in all age groups. The specific areas of inquiry might include cancer prevention, exercise and physical fitness, diet and nutrition, general functional maintenance (e.g., home living, etc.).

7. Research on cost, reimbursement, and technology as applied to the elderly. This would include research on the impact of changes in government regulations, public policy hospital regulations, and other medical economic issues on the elderly.

8. Research into ethical decisions of medical care. Because of the growing concern of limited resources and the urge to maintain the best value for limited dollars, the elderly are at significant risk for adverse actions in this regard. Inquiries into the rational basis for ethical decision-making will be of great importance.

9. The most rapidly increasing portion of our older population is the "oldest old," and since there is relatively little experience with this component of the elderly population, investigation into characterizing the physiology, clinical, social, and economic characteristics of this population group is of great importance if we are to anticipate medical care needs for the future.

10. Mental illness in the elderly population is clearly a major cause of morbidity and suffering. Our knowledge of the epidemiology, etiology, pathophysiology, and treatment of mental illness in the elderly is severely limited, and more research is clearly needed.

C. Funding for Research and Research Training

1. The core and critical mass of researchers in geriatric medicine and relevant areas must be increased and stimulated by mechanisms to seek increased funding both for training and long-term support of programs in these areas. The importance of research must be stressed at all levels in geriatric and general training programs, and efforts must be made to encourage investigators from other relevant areas of research to apply their talents to research in geriatric medicine.

2. We recognize the outstanding contribution of the National Institute on Aging in stimulating and

supporting research in geriatrics and gerontology and in increasing funding for research through its own efforts and through cooperative funding for aging-related programs with other institutes.

3. We recognize and commend the efforts of the Veterans Administration to fund research in geriatric medicine through the GRECC program and others and urge increased targeted support to aging and geriatrics research through this agency.

4. A number of major private foundations have adopted research in geriatrics as a pertinent and important area for funding. The need for such support is increasing, and we encourage other foundations to consider this geriatric and gerontology research as a funding priority.

5. The support given funding for research on the problem of aging and the elderly by a significant number of members of Congress is recognized and appreciated. It is extremely important that this support be continued at a time when cutbacks are under consideration.

AGS POSITION STATEMENT ON DRUG TESTING AND SURVEILLANCE IN ELDERLY PERSONS

(This position paper was developed by the Public Policy Committee and approved by the Board of Directors in July 1985. This, like other Society position statements, is in constant evolution. We invite readers to send us their comments and suggestions for revisions.)

Background

There currently exists no systematic and rigorous means of ensuring that the effect of drugs on elderly subjects is adequately measured in premarketing trials of drugs, even though there is ample evidence that elderly patients often react in very different ways to medications than their younger counterparts. Moreover, the elderly often constitute a major proportion of the patients that use new drugs. In a number of instances (for example, with Oraflex), failure to assess the effect of drugs specifically in the elderly population has had tragic consequences.

Positions

1. The Food and Drug Administration (FDA) should develop explicit guidelines that insure the inclusion of adequate numbers of elderly persons in all drug trials, including those for pharmaco-dynamic considerations, for drugs that are likely to be used by elderly persons.

2. Special safeguards should be taken for protection of elderly pesons in drug trials, especially those with sensory or cognitive impairments.

3. An effort should be made to inform the elderly of the benefits and desirability of voluntary participation in carefully controlled clinical drug trials.

4. The FDA should require drug package inserts and advertising to include information concerning pharmaco-kinetics of the drug and its metabolites in older persons, approximate dosages for elderly individuals, or an explicit statement that no adjustment is needed.

5. A systematic surveillance mechanism should be developed that would serve to monitor the potential toxicity and interactions of drugs in elderly persons.

6. Additional funding is needed for studies of the current patterns of drug use by elderly persons, including issues of compliance, side effects, and efficacy.

7. Drugs already on the market that are used by the elderly and that have not been appropriately tested in persons over the age of 65 should be identified as such in prescribing instructions such as package inserts and in other appropriate literature.

AGS POSITION STATEMENT ON THE USE OF DRUGS OF QUESTIONABLE EFFICACY IN THE ELDERLY

(This position paper was developed by the Public Policy Committee and approved by the AGS Board of Directors in July 1985. This, like other Society position statements, is in constant evolution, and we invite readers to send us their comments and suggestions for revisions.)

Background

The National Academy of Sciences and the Food and Drug Administration (FDA) and have found relatively little evidence supporting the effectiveness of a substantial number of prescription drugs. Over-the-counter therapies having no proven benefit have also been identified. While patients of all ages are negatively affected by the availability of minimally efficacious drugs, the elderly are at particularly high risk.

The use of ineffective or marginally effective drugs places a considerable burden on the elderly. First, the drug may pose significant risks of toxicity, particularly in those with impaired kidney and liver function and altered sensitivity to some drugs. Second, drug purchases currently represent one of the highest out-of-pocket health expenditures for the elderly.

Positions

1. The FDA should make a concerted effort to remove from the market those drugs that have been determined by the National Academy of Sciences/National Research Council to be marginally effective or ineffective.

2. Refusal of reimbursement by various payers for use of ineffective medications is a positive step. Such medications should also be removed from the formularies of hospitals and long-term care facilities.

3. Extensive educational efforts are needed that would make both elderly patients and physicians aware of the ineffective nature and potential risks of the use of these preparations. Support for such activities should come from private, governmental, and foundation sources.

AGS POSITION STATEMENT ON MEDICAL TREATMENT DECISIONS CONCERNING ELDERLY PERSONS

(This position paper was developed by the Public Policy Committee and approved by the AGS Board of Directors in May 1984. This, like other Society position statements, is in constant evolution. We invite readers to send their comments and suggestions for revisions.)

Background

The past few decades have seen much controversy and confusion over the limits of medical intervention. This is due to reasons such as increasing efficacy of medical techniques, the increasing burden of chronic illness in the population, the declining availability of close family members, and increasing litigation. Decisions regarding the application of medical treatments to particular patients once concerned only a small group of involved persons. However, these decisions are now commonly subject to the attention of the public, large groups of people providing care in institutional settings, and law enforcement officials. This change has led to a need to be explicit about values; and, as would be expected in this pluralistic society, there have arisen profound disagreements over these values. Carefully developed guidelines for standards and procedures prove helpful to guide caregivers, patients, and public policy. Such guidelines reflect (1) a strong commitment to personal autonomy, (2) both an appreciation of the beneficial potential of modern medicine and honesty regarding its side-effects and limitations, and (3) both an affirmation of the inestimable value of life and a clear recognition of the inevitability of death.

Positions

1. Decisions regarding medical care should be made to improve the individual patient's overall health as much as possible within the context of legitimate legal, financial, organizational, and ethical constraints.

2. Patients' interests are not always best served by applying all theoretically beneficial treatments. Instead, the choice made should reflect that patients often have legitimate concerns about avoiding suffering, advancing their occupational family concerns, mitigating disability, and sustaining independence. Particular medical interventions may not be warranted in light of their overall effects, even though they may be expected to help a particular medical condition.

3. Physicians should communicate with patients and families so that choices regarding care reflect each patient's own priorities and evaluations of various projected outcomes.

4. When patients can be adequately informed and are

capable of making a reasoned choice, their own decisions should be determinative except when there are substantially detrimental effects upon others.

5. When patients cannot be informed or cannot reason about the available options in light of their own preferences and goals, the physician should, for any important or ambiguous choice, involve someone who knows the patient and can represent the patient's wishes in making a choice. This surrogate is often a close family member but could be a concerned friend. If the patient has no appropriate surrogate, practitioners and institutions should arrange for substitutes by developing procedures (such as biomedical ethics committees) that do not require routine recourse to formal guardianship proceedings.

6. Whenever possible, the patient should be encouraged to state his or her preferences in advance of decision-making incapacity. Such a statement can be informal but should be appropriately noted in the medical record. Also, patients should be encouraged to make appropriate use of durable power of attorney and living will statutes.

7. Caregiving professionals and institutions should make available to patients a full range of options for treatment, including the option of supportive care for dying patients.

8. Legislation at the state level is needed in some areas to insure the availability of a range of options for patients, including statutes defining durable powers of attorney and carefully structured living wills. Such legislation would provide authority for decision-making by appropriate surrogates and physicians without needing formal guardianship proceedings in most cases.

AGS POSITION STATEMENT ON MENTAL HEALTH AND THE ELDERLY

(This position paper was developed by the Public Policy Committee and approved by the AGS Board of Directors in March 1986. We welcome readers' comments and suggestions for revisions.)

Background

Mental illness is an important contributing factor to the disease burdens of the elderly. While the elderly do not appear to suffer a disproportionate share of most classifiable mental illness (such as depression or schizophrenia), they do have a much higher prevalence of the dementing illnesses such as Alzheimer's disease and multiple personal losses of social relationships affecting daily existence. Even in those instances where the prevalence of mental illness such as schizophrenia may actually be lower in the elderly, the proportion of elderly persons receiving adequate treatment is markedly lower than in younger groups. This underprovision of services persists despite the fact that any treatment of mental illness such as depression or paranoia in the elderly has been shown to be as effective as treatment in younger groups. Undertreatment of mental illness in the elderly appears to be a significant factor in the high suicide rate among elderly men, as well as in the premature or inappropriate placement of elderly persons in nursing homes.

Research on mental illness in the elderly has been, until very recently, ignored and neglected. Even with the attention that has been given to the existence of large numbers of patients with Alzheimer's disease, funding for research in comparison to the frequency and devastating nature of mental illness in the elderly remains inadequate.

Positions

1. The severe restrictions on Medicare reimbursement for mental health services should be eliminated. Reimbursement for mental health services provided in home visits, outreach and case finding programs, nursing homes, group residences, and community centers for the elderly are especially critical.

Rationale: Significant barriers exist for the elderly in accessing and utilizing mental health services. Coverage under Medicaid is inadequate and serves to further the myths that mental illness in the elderly is to be expected and is not responsive to treatment. Despite twenty years of inflation and increased health care costs since the inception of Medicare, the elderly are still limited to a $250.00 annual cap for mental health care. A number of studies have shown the high cost in terms of hospitalization and over utilization of medical visits where ambulatory mental health services are overly restricted. More importantly, current financing of mental health care does not reflect the pharmacologic and neurologic/biologic advances in psychiatric care and the fact that treatment of elderly patients can be just as successful as treatment in younger persons.

2. The National Institute of Mental Health should continue to fund at an adequate level the development of training programs in interdisciplinary mental health care for the elderly in the four basic areas of expertise: clinical social work, psychiatry, psychiatric nursing, and psychology.

Rationale: Most community surveys suggest that one percent (1%) or less of elderly persons in the community receive psychiatric care. Evidence that the elderly remain underserved by mental health providers includes:

- Only four percent (4%) of community mental health center patients are over 65;
- Two percent (2%) of the patients seen by private practioners are elderly; and
- Less than one and one-half percent (1.5%) of all community-based mental health care goes to the elderly.

Further surveys of professionals in mental health have shown that very few have received specific training in the care of elderly persons with mental health problems.

3. There should be immediate expansion of research programs funded by the National Institute of Mental Health and other agencies on etiology and treatment for depression, paranoia, the dementing disorders, and other mental illnesses affecting elderly persons.

Rationale: Mental illness, including depression, paranoia, and the dementias (including Alzheimer's disease) are clearly among the most physically, emotionally, and economically devastating illnesses that commonly affect elderly persons. By some accounts, over fifteen billion dollars a year are spent on care for victims of dementias alone. The financial and emotional burden placed on caretakers and other family members of those elderly persons with mental illness is often overwhelming. Research on the epidemiology, pathophysiology, and effective treatment of mental illness in the elderly is critical to finding ways to ameliorate or prevent these illnesses.

AGS POSITION STATEMENT ON ALLOCATION OF MEDICAL RESOURCES

(This position paper was developed by the Public Policy Committee, approved by the AGS Board of Directors in November 1984, and revised in July 1985. We invite readers to send us their comments and suggestions for further revisions.)

Background

The allocation of medical care is a social and ethical issue that occurs in a medical context and involves physicians. The development of life-sustaining medical technologies and the concern for accountability and medical cost containment may lead to the rationing of medical care.

Rationing of medical care requires explicit, understandable, defensible policies with safeguards to ensure fairness and maximal benefit. The need to ascertain that scarcity exists is especially important.

Positions

1. Careful, reasoned, and full public debate based on an adequate knowledge base should ensue before decisions are made to further limit the allocation of resources to health care.

   Rationale: It is not at all apparent to what degree scarcity of resources actually exists in United States medical care. The crisis atmosphere generated by the growth of health care spending to a level of approximately 11% of the gross national product must be viewed in its social context. Other Western industrialized countries spend even more of their gross national product on medical care without generating the same sense of crisis. As a society, we do make decisions concerning the allocation of resources in an overall sense on the amount that we want to spend on health care as opposed to other social needs. However, failure to approach these issues in a careful and sensitive way with due concern for scholarly inquiry and public understanding is likely to lead to changes that are inequitable and otherwise damaging to our society.

2. A person's chronological age, per se, should not be used as a criterion for his or her exclusion from a given therapy.

   Rationale: The physiologic aging of people occurs in a widely variable manner. One cannot generalize about the prognosis or usefulness of treatment for any condition based solely on a person's chronological age.

3. Considerations of resource distribution should not outweigh the physician's effort to maximize an individual patient's welfare in a given doctor-patient relationship. However, physicians can and should provide a significant voice in the national debate on spending priorities.

Rationale: The individual doctor-patient relationship relies on a living history of trust that the physician will do what is in the best interest of that patient. Decisions to limit or ration care may conflict in a basic and substantial way with that principle. In extreme situations such as those encountered in natural disasters and in combat, physicians may need to choose between competing needs of different patients. Such situations are quantitatively different from those involved in allocating resources among different persons and different social goods within a society. However, physicians, both as individuals with expertise in medical care and as advocates for their patients, can and should participate in public discussion and debate concerning the allocation of resources between various needs of society. Further, physicians also should play a role in resource allocation among various types of care within the health care area.

4. The higher per capita expenditures on medical care in the elderly is appropriate given the greater need for medical care in that age group.

   Rationale: Simply because elderly persons as a group use more medical care is not a de facto reason to reduce expenditures on medical care of the elderly. Medical care exists largely for the care of sick people, and sickness happens to a greater degree as one gets older.

5. Efforts to allocate medical care should focus on unnecessary spending and waste in all areas of medical care, not just on programs supported by public funding.

   Rationale: Inappropriate tests and interventions occur in the medical care of both the old and the young. There is clearly waste and unnecessary spending in our health care system that must be addressed before we begin to consider reductions in basic health care benefits. Most of the focus on cost savings thus far has been on publicly funded programs such as Medicare and Medicaid. Such a focus creates the impression that only publicly funded programs are subject to waste and unnecessary spending and that the elderly and poor receive a major share of unnecessary care. There is then a high likelihood that the elderly and poor will be singled out as scapegoats and that funding for clearly beneficial programs for the poor and elderly will be reduced at a time that waste and inefficiency exist in the medical care of other groups.

AGS POSITION STATEMENT ON THE PHYSICIAN'S ROLE IN THE NURSING HOME

(NOTE: This position paper was developed by the Public Policy Committee and approved by the AGS Board of Directors in July 1985. It will be used to guide future Society responses to issues concerning nursing home care by physicians. This, like other Society position statements, is in constant evolution, and we invite readers to send their comments and suggestions for revisions.)

Background

Physicians have an essential role in the delivery of medical care across the continuum of the health care system. The care of the chronically ill or frail elderly necessitates physician assessment and intervention on a regular and timely basis. Physician visits to a nursing home assure that medical knowledge and skills are incorporated into the care of residents and can provide knowledge, education, and psychosocial support for the patient, patient's family, and other caregivers. Given recent Medicare reimbursement changes, the complexity and severity of medical problems of persons in nursing homes is increasing, which in turn increases the need for physician involvement.

The traditional ethical and legal commitment of physicians to patient care dictates that physicians assume direct and ongoing responsibility for the medical care of nursing home patients. Part of that commitment is to assure that nursing home residents have access to medical services that are comparable in quality to those provided in the community. The chronic nature of most nursing home residents' illnesses requires ongoing physician attention to the psychological support and education of patients and families as well as the treatment of the disease itself.

Positions

1. Medical societies, legislative bodies, and regulatory agencies should work to insure that a sufficient number of motivated and knowledgeable physicians are available to provide personal medical care and medical direction in nursing homes.

2. Frequency of physician visits to nursing home residents should be based on the patient's needs.

3. Improved access will require education of physicians concerning the problems and needs of nursing home residents as well as incentives, including adequate reimbursement, that will attract highly qualified physicians to the nursing home setting.

4. Personal medical care in nursing homes should encompass the usual areas of medical practice such as the care of acute episodic illnesses and monitoring of chronic disease. It should also include participation in the assessment of need for rehabilitation or maintenance therapy to improve or maintain patient function and the provision of education and psychological support for the patient's family and other caregivers. The physician should be an active

member of the team of professionals providing care in the nursing home.

5. Physicians providing medical direction in nursing homes have a responsibility to provide leadership in developing, implementing, and carrying out policies and procedures concerning at least these areas:
    a. organizing and allocating services;
    b. educating non-physician staff who provide clinical care;
    c. assuring appropriate use of beds and resources;
    d. assessing quality of care;
    e. granting and reviewing privileges of physicians and non-physician medical practitioners; and
    f. participating in care decisions that affect a person's longevity and quality of life.

6. All physicians who provide care in nursing homes should be willing to participate in and support the activities outlined above.

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AGS POSITION STATEMENT ON PUBLIC FINANCING OF MEDICAL CARE FOR THE ELDERLY

(EDITOR'S NOTE: This position paper was developed by the Public Policy Committee and approved by the AGS Board of Directors in March 1986. This, like all Society position statements, is in constant evolution. We invite readers to send us their comments and suggestions for revisions.)

Background Increasing expenditures for medical care over the last decade, have served to focus attention on publicly supported programs of medical care, most notably Medicaid and Medicare. Reports from the Congressional Budget Office and the trustees of the Hospital Insurance Fund in 1983 state that the fund from which payments for Medicare Part-A are disbursed will be depleted in the early 1990s. Congressional attention to Part-B of Medicare and Medicaid was largely the result of the marked increase in general revenue funds required for the support of these programs.

The result of this congressional attention included the far-reaching changes in the Medicare Prospective Payment System for hospitals using diagnosis-related groups (DRGs) that went into effect in October 1983 and the Medicare physician payment freeze, which was mandated by the Budget Deficit Act of 1984. These and other legislative and administrative changes have had a profound impact on hospital length-of-stay and on physician reimbursement as they relate to the care of the elderly. The effect of these changes on overall Medicare or Medicaid costs has yet to be determined. However, major concerns have been raised as to the effects of these changes on access to and the quality of care for recipients of publicly funded health care.

Positions A. General Issues

1. It is imperative that the Medicare program be assured of continuation and solvency.

Rationale: The Medicare program has had a major positive effect on the access to and the quality of medical care provided to elderly persons. Efforts to limit access to Medicare by means such as increasing the age of eligibility or means testing, are not equitable or desirable.

2. A significant proportion of actual cost-savings generated from more appropriate use of hospital admissions or technical services by physicians should be used to expand Medicare to meet the needs of elderly persons with catastrophic illnesses, including those illnesses such as dementia whose predominant effect is on the need for home care and nursing home services.

Rationale: As more and more Americans live to the oldest age group (e.g., those over 85), there may be a rise in the number of persons who exhaust their Medicare hospital benefits. Likewise, gaps in coverage for home care services, mental health services, respite care, and nursing home care for those with progressive chronic disease result in a significant burden on individuals and families.

3. Cost containment efforts by federal and state governments must not disrupt financial support to protect frail, vulnerable individuals and the persons who care for them.

Rationale: Payment mechanisms should fairly compensate hospitals and physicians for providing necessary care to their patients, so that patients do not become, in effect, financial "winners" and "losers." Specifically, the current system of hospital reimbursement and any new system of reimbursement for physicians, nursing homes, or home care services requires a case-severity adjustment factor or similar means to allow equitable compensation for care of very complex, time-consuming patient problems.

4. Cost containment efforts should apply to all areas of medical care financing and not only to publicly funded programs such as Medicare or Medicaid.

Rationale: Cost containment programs that are limited to reducing expenditures in publicly funded programs or that cause a disproportionate share of the reductions to fall on the population served by public programs are likely to reduce access and the quality of care for those individuals relying on public programs. Undue attention focused on publicly funded programs for the poor and the elderly that ignore costs in other sectors of the health care system is a form of discrimination.

5. Efforts to increase competition in medical care delivery must be carefully structured and closely monitored to prevent underprovision of services for those elderly persons unable to make informed choices or whose levels of need for health care make them major financial risks for provider groups.

Rationale: Reimbursement mechanisms should provide for adjustment of payment for severity of illness and functional capacity in order that the frail elderly are not excluded from health care organizations because reimbursement for them in relationship to costs is perceived or shown to be significantly less than for other groups. Marketing efforts by HMOs and PROs should be monitored to assure that elderly patients who are unable to make informed choices or who may be major financial risks are not discriminated against.

B. Physician Services

1. Administrative decisions by the Health Care Financing Administration or Medicare carriers to reduce expenditures by redefining benefit guidelines and, specifically, redefining terms such as "homebound" or "medically necessary" should not be permitted unless there is a meaningful opportunity for public comment and Congressional review.

Rationale: Administrative changes appear to be used with increasing frequency as a means of reducing benefits, limiting eligibility, or lowering reimbursement. Such changes often subvert the legislative intent of Congress to provide health services to the elderly, and they place major economic burdens on the frail elderly, their families, and those professionals caring for them.

2. Recognition of the complexity of cognitive skills needed in the care of elderly persons should be considered, as well as re-evaluation of the appropriateness of charges for technical procedures.

Rationale: Since Medicare's inception, payment for services involving technological procedures has increased more rapidly and disproportionately in comparison to direct patient care management (so-called cognitive services). This has resulted in over-utilization of technology and a strong incentive to underutilize cognitive services that might reduce or eliminate the need for expensive technologies.

3. Continuation of the freeze on physician reimbursement under Medicare will be detrimental to the overall care of elderly patients.

Rationale: The fee freeze has actually accelerated the current inequities in reimbursement by failing to control the number of services or high cost technical procedures. It most heavily penalizes those physicians who have shown restraint by holding down fees in the pre-1983 period of high inflation, and those physicians whose practices are made up predominantly of elderly persons, especially frail elderly patients. The current policy also encourages physician subspecialization and discourages primary care.

4. Profiles used by Medicare carriers to monitor "unnecessary" care should consider geriatrics as a primary or secondary specialty.

Rationale: Given the large disease burden of the frail elderly who constitute a large proportion of most geriatric practices, physicians caring for such patients will obviously have more nursing home visits, more frequent office visits, and more prolonged hospital stays than physicians whose practices do not focus on the frail elderly patient. Surveys and monitoring procedures that do not recognize the unusual profiles of those physicians caring for large numbers of frail elderly will result in wasted administrative efforts and fewer qualified physicians willing to care for the frail elderly patient.

Senator MATSUNAGA. Well, thank you very much, Dr. Lindsay. You did it while we were still on green here, and I suppose you were thinking about the Subcommittee members whom I promised I would not keep later than 4:30. [Laughter.]

In the interests of time, we will send you any questions in writing for you to respond for the record, and I wish to thank you again, because we still have another panel of witnesses.

Dr. LINDSAY. Thank you.

Senator MATSUNAGA. Thank you very much.

Our final panel of witnesses today represents national sponsors under Title V community service employment programs, and with us today are Mr. William R. Hutton, the Executive Director of the National Council of Senior Citizens; Ms. Janet Zobel, the National Director of the National Urban League's Seniors in Community Service program, who I understand will be speaking on behalf of Dr. Douglas Glasgow, Vice President of the National Urban League, who, I understand, due to some kind of an emergency could not be with us today; and Mr. Alec G. Olson, Administrator of Green Thumb, Incorporated. I thank you all for coming and for waiting so patiently, being members of the last panel.

We would be happy now to hear from you, Mr. Hutton.

STATEMENTS OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC; JANET ZOBEL, NATIONAL DIRECTOR, SENIORS IN COMMUNITY SERVICE PROGRAM, NATIONAL URBAN LEAGUE; AND ALEC G. OLSON, ADMINISTRATOR, GREEN THUMB, INCORPORATED, FALLS CHURCH, VA

Mr. HUTTON. Thank you, Mr. Chairman. I am William R. Hutton, as you said, Executive Director of the National Council, and I would appreciate it very much if you can submit my entire testimony for the record and I will spend a few minutes in giving some of the highlights.

Senator MATSUNAGA. Your full statement will appear in the record as though presented.

You may begin, Mr. Hutton.

Mr. HUTTON. Chairman Matsunaga, the National Council of Senior Citizens has been a sponsor of Title V, which we call the Senior AIDES Program, A-I-D-E-S. It is an acronym and it stands for—Alert, Industrious, Dedicated, Energetic Seniors, Mr. Chairman.

Every independent study of the program, including one completed just last year under contract to the Department of Labor, has concluded that Title V is meeting vital needs in the nation; that it is cost effective, and that it is well managed and operated by the Department of Labor and the eight national contractors and the States.

The success of the Title V program can be attributed to its original concept that older workers with limited incomes have a vital role to play providing essential community services. It is neither a welfare program nor a make-work program.

Our staff monitors job sites on a systematic basis to assure that Senior AIDES are employed in meaningful jobs and they are providing needed services. For most Senior AIDES, a modest part-time salary of about $3,500 a year represents the difference between dependency on SSI, food stamps and other public assistance programs or sustaining a financially independent way of life, a vital difference.

For many older participants, the senior AIDES program also represents the road back to full or part-time work, unsubsidized by the government. Our extra aide program authorized under Section 502(e) of the Act prepares older workers for unsubsidized jobs as office managers, computer operators, bank tellers, and home health care providers.

As a result of job training and placement efforts such as these, this year we expect to help 20 percent, or more than 2,000, of our Senior AIDES make the transition into private sector jobs.

While there has been talk about problems in coordinating throughout our nearly two decades in operating this program, NCSC has had relatively few problems with respect to this issue among Title V sponsors.

We are in compliance with and will continue to work toward meeting the requirements of Section 503(a), which mandates us to consult with State and area agencies on aging regarding the location of projects and the assessment of community needs.

In the area of equitable distribution, NCSC considers itself a leader in working with States and other national sponsors to ensure that opportunities to participate in Title V are fairly dispersed to those in need of jobs.

We have launched new projects in some instances, we have reduced enrollment in others, and we have conferred and consulted with the governors and State agencies at every opportunity. Similarly, we cooperate and coordinate with the JTPA and Job Corps programs throughout the nation.

Mr. Chairman, while some federal programs may warrant significant structural or administrative adjustments to bring about improvement, in the case of Title V we have a time-tested, successful program that has consistently proven its worth.

We are opposed to the imposition in Title III of new fees for services. Finally, we believe there is a great need for more in-home services for the frail elderly in the Title III program. We think that no changes are really needed in Title V.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hutton follows:]

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Reauthorization of the Older Americans Act

Testimony Presented Before

the

Subcommittee on Aging
Senate Committee on Labor and Human Resources

By

William R. Hutton
Executive Director

April 30, 1987

Washington, D.C.

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Good afternoon Chairman Matsunaga and Members of the Subcommittee. I am William R. Hutton, Executive Director of the National Council of Senior Citizens. On behalf of our members, I would like to thank you for this opportunity to present our views on the reauthorization of the Older Americans Act (OAA).

Over its 22-year history, the Older Americans Act has adapted and grown to address the changing needs of an aging population. It remains a vital avenue of service delivery and employment opportunity for millions of older persons. Like others who have come before this Committee, NCSC believes that no major restructuring of the Act is called for in this reauthorization. But we do recommend some fine tuning which would improve services for those who most need them.

We will direct our comments to Titles III and V of the Act.

Title III

Services for the Frail Elderly

There is a pressing need for more resources for Title III programs. During the past six years, OAA funding has been stagnant and has failed to keep pace with the demographics of an aging society. Not only are more persons living to be 65 and older, but the fastest-growing age group is comprised of those 85 and older.

Whereas 9.4 percent of the elderly were at least 85 in 1985, by 2010 this proportion will be nearly 17 percent--an increase of almost four million individuals. The very old are far more likely to be frail and impoverished than their younger counterparts, creating greater demand for costly services.

Another group of persons requiring more in-home care are those released early from the hospital as a result of the DRG system. For these persons, a short period of services may be all that is required. For those with chronic problems, in-home and community-based long-term care services can help them remain independent, preventing expensive and unnecessary institutionalization.

NCSC strongly believes that in-home services must be expanded. A recent GAO report found that 3.2 million elderly persons required assistance with such activities as eating, getting in and out of bed, dressing, using the bathroom, preparing meals or leaving home. But only 1.9 million said they got all the help they need from relatives, friends or household aides or health workers. The rest——nearly 1.3 million——said they need more help with basic activities.

Clearly, there is a terrible shortage of available services. The Older Americans Act cannot and should not meet all these needs. For example, Medicare home care services must be expanded. But OAA funds can support the provision of many in-home services vital to the independence and dignity of the frail elderly.

Targeting of Services

An issue of very great concern to NCSC is targeting of services to low-income and minority elderly. We are greatly disturbed that Administration on Aging data reveal a significant decline in participation by these vulnerable groups over the last six years. (See Appendix A.) In our opinion, the structure of the Act, which requires targeting to persons with the greatest needs yet prohibits the stigma of means testing, is excellent.

However, we believe that, in light of declining participation by poor and minority elders, the time has come for more explicit direction by Congress as to how targeting may best be achieved. Our recommendations address each level of the aging services network.

At the national level, we are concerned that the program's funding formula, which looks only at each state's share of the nation's population aged 60 and older, may not provide adequate resources to those areas with greatest need. We do not advocate any upheaval in current funding allocations. Rather, we think that new funds, over the FY 1987 appropriated level, should be allocated using a more sensitive formula.

By weighing a number of risk factors associated with greater need, we think OAA service delivery could be improved. These risk factors include poverty, minority status, numbers of rural elderly and the very old. The latter three factors are all associated with disproportionate poverty rates.

At the state level, we strongly believe the intrastate funding formula must be required to include these factors in allocating resources. Furthermore, we believe the states should evaluate and report on their success in serving these vulnerable groups.

Likewise, the Area Agencies should be accountable for how well they serve those most vulnerable, especially the poor, and document the areas of unmet need in their communities.

At the service provider level, outreach is already required and we believe such efforts should be directed toward the poor, be they frail, minority or rural elderly.

Fees for Service

The structure of the Older Americans Act currently allows service providers to solicit "voluntary contributions" for meals served. Such fees are useful to the extent that they expand the number of meals served and allow those with adequate resources to offset the Federal subsidy for the program.

There may be a conflict, however, between the worthy intent of a contributory system and its impact on participation by low-income seniors. Despite the requirement that services be targeted to those with greatest social and economic need, over the past six years, low-income participants have comprised smaller and smaller percentages of persons served. Concomitantly voluntary contributions have soared from $79 million in 1979 to $140 million in 1985.

It is unknown whether this correlation is the sole, or even the most significant, reason for declining participation by low-income persons. Low-income participation in the supportive services component of Title III has also plummeted, although fees are not now permitted for those services. But some anecdotal evidence from service providers has indicated that increased emphasis on contributions can deter participation by the poor, who are unable to afford higher fees.

The National Council of Senior Citizens believes it is imperative that further study be conducted as to the potential impact of contributions on low-income participation. We think it would be a serious mistake to begin to impose new fees or voluntary contributions for supportive services, as some are advocating, until more complete information is available on the effects of current practice. Expansion of services must not be at the expense of low-income participation.

Outreach

It is unfortunate that many service providers cannot meaningfully conduct outreach because they are already serving to capacity and maintaining waiting lists. We believe, however, that a very important service could be provided by the OAA network to those seniors who come into contact with these agencies. Specifically, we would like to see service providers play a greater role in disseminating information about other programs for which seniors might be eligible——for example, food stamps, SSI, Medicaid and energy assistance.

Participation rates by the elderly poor in these programs are abysmally low. Studies to date have singled out lack of information as the greatest factor in non-participation. None of these important programs reach much over one-third of the elderly poor.

We believe the friendly and non-stigmatizing environment of the senior center or other community facility, combined with information and assistance, could make real inroads in helping older persons receive benefits for which they are eligible and which could enhance the quality of their lives.

In 1985, amendments to the Food Stamp Act were approved which require Social Security offices to provide information and assistance on food stamps to applicants for and recipients of SSI. The U.S. Department of Agriculture must reimburse the Social Security Administration for the related expenses. We believe a similar arrangement could be applied to the Older Americans Act. This would allow expansion of vital services without causing financial hardship for the aging network.

Advocacy

NCSC believes the advocacy role of the OAA is one of its most important functions. We are disturbed that the 1985 regulatory overhaul of the Act may have given a message to the aging network that advocacy is no longer important or, in some cases, acceptable.

The regulations state that advocacy efforts may not, "supersede statutory or other regulatory restrictions regarding lobbying or political advocacy with Federal funds." This chilling language replaced provisions which called for the aging network to represent the interests of the elderly before state and local legislative and regulatory bodies.

NCSC believes this language should be restored. A 1985 memorandum prepared by the Congressional Research Service addressed this issue and found that, "There appears to be, in fact, no Federal statute specifically applicable to private recipients of funds distributed by Federal agencies as to the 'lobbying' of state or local governmental agencies or units by those private recipients when consistent with the purposes of the grant program." Furthermore, the memorandum notes that the well-known Office of Management and Budget (OMB) Circular A-122, which has been taken by many to prohibit all lobbying with Federal funds, in fact, says that grant recipients may use Federal funds for "any activity specifically authorized by statute to be undertaken with funds from the grant, contract or other agreement."

It would appear that lobbying state and local legislative and regulatory bodies is, in fact, already allowed, but we do not believe this is clear to the aging network. Congressional action could help clarify this issue.

Title V

Mr. Chairman, there is no program under the Older Americans Act with which we are more familiar or more proud than Title V, the Senior Community Service Employment Program. As you know, the National Council has been a sponsor of Title V——which we call the Senior AIDES Program——since its inception in 1968. As one of the three original sponsors, we have seen Title V grow from a $10 million demonstration project to a program that will provide employment opportunities to over 61,000 low-income older men and women this year.

The expansion of Title V over the past two decades reflects the program's tremendous popularity and importance in towns and cities across the country and its unparalleled bipartisan support here in Washington. Every independent study of the program--including one completed just last year under contract to the Department of Labor--has concluded that Title V is meeting vital needs in the nation; that it is cost-effective; and that it is well-managed and operated by the Department of Labor, the eight national contractors and the states. It would be very hard to find another Federal program that has received such positive and consistent comments after repeated studies. We at NCSC are very proud, as we are sure all other sponsors are proud, of this record. We have worked hard to make Title V what it is today and we continually seek ways to build upon past accomplishments.

The success of the Senior Community Service Employment Program can be attributed to its original concept that low-income older workers have a vital role to play in meeting essential community services. It is neither a welfare program nor a "makework" program. Senior Aides work twenty hours a week and are compensated at the Federal minimum wage or at an hourly rate commensurate with the prevailing wage of the job performed. Moreover, at NCSC, our staff monitors local projects closely and frequently to make certain that the jobs to which Senior Aides are assigned are meaningful and that they are responsive to well-identified community needs.

We are all aware that Federal, state and local human service budgets have suffered severe cutbacks during the past several years. In many cities and counties, the only resource available to maintain vital services or to initiate needed new services has been through the help of Title V participants. Seniors Aides have always worked in child and adult day care centers, in libraries, in nutrition programs, in outreach and referral centers, in fire and crime prevention programs, and in transportation projects which help local seniors to get to their doctors, pharmacies and grocery stores.

In recent years, however, we have seen Senior Aides also working in shelters for the homeless, in centers caring for abused children, in food banks aiding disadvantaged people of all ages and in soup kitchens providing hot meals for street people. They are helping to fill the pressing need discussed earlier as providers of in-home care for the frail elderly. They work in public hospitals to provide help for families and victims of Alzheimer's Disease and, in several locations across the country, Senior Aides operate highly successful job placement services for young people as well as other older workers.

While the services that Senior Aides provide are clearly vital in their communities, we should not overlook the benefits which the older workers themselves derive from participation. First, they earn a salary; on average $3,500 a year before deductions. For most enrollees, this represents the difference between dependency on SSI, Food Stamps and other public assistance programs or sustaining a financially independent way of life. Perhaps equally important, they gain dignity, confidence, new job skills and a tremendous sense of satisfaction and accomplishment from being engaged in useful work which contributes to the quality of life of an entire community.

For many older participants, the Senior AIDES Program also represents the road back to full or part-time employment, unsubsidized by the government. In 1987, for the sixth consecutive year, the National Council of Senior Citizens was authorized to conduct special training designed to prepare older workers for jobs in the private sector. The "EXTRAide Program" provided under Section 502(e) of the Act, prepares older workers for jobs as building managers, computer operators, bank tellers, word processors, child care and home health care providers.

All the Title V sponsors have promoted job training and placement efforts such as these in order to meet the Department of Labor's unsubsidized placement target of 15 percent. This year, DOL has set the goal at 20 percent. At NCSC, we came very close to that goal last year; we were more than halfway there at the end of the second quarter this year, and we expect to be on target on June 30th. Together with the other Title V sponsors, we will continue to stress to private employers, to public and nonprofit agencies, and to anyone else who will listen, the value of the experience, maturity and reliability which older workers bring to their jobs.

Successfully accomplishing the goals of Title V——jobs for older workers with limited incomes, meaningful and useful community services and placement into unsubsidized employment for many——has been possible and continues to be because of the flexibility which has characterized the administration of the program by the Department of Labor. DOL has realized that the various participants in the program may have different approaches to meeting program goals, and, thus, has given significant discretion in operation to the several sponsors. While affording flexibility, DOL has also insisted upon strict adherence to all sections of the Act, as well as the Federal regulations. The present administrative arrangement is one of the major strengths of the Title V Program; it is an arrangement which has succeeded and should remain unaltered.

Although there has been much talk about problems in coordination throughout our nearly two decades operating this program, NCSC has seen relatively few problems with respect to this issue among Title V sponsors. We are in compliance with and will continue to work towards meeting the requirements of Section 503(a) of the Older Americans Act, as amended, which mandates us to consult State and Area Agencies on Aging with regard to the location of needed projects and the assessment of community needs to be met by such projects. We also adhere to DOL requests by cooperating and coordinating with the JTPA and Job Corps programs across the nation.

The effective application of this provision can be evidenced in the area of equitable distribution, a focus of legitimate concern in recent years. Although we have yet to completely alleviate the problem, NCSC considers itself a leader in working with states and other national sponsors to ensure that opportunities to participate in Title V are fairly distributed and available to those most in need of jobs. We have launched new projects in some instances; we have reduced enrollment in others; and we have conferred and consulted with appropriate state agencies at every opportunity.

In truth, some of the most innovative projects we administer today were borne out of equitable distribution goals. Two years ago, no Title V sponsor was addressing the growing needs of the low-income Asian community in Los Angeles. With the help of increased funding and by transferring resources from "over-served" regions in California, NCSC founded a Chinatown Senior AIDES project. Working in cooperation with the Chinese Committee on Aging, this Title V project is meeting the varied needs of the non-English speaking Asian community. Senior Aides work as interpreters in Social Security offices, police stations, community service agencies and in the Superior Court. They staff literacy programs, employment services, crime prevention programs and work in senior nutrition and housing sites. NCSC operates a similar project in conjunction with the Chinatown Planning Council, Inc., in New York City.

Taking steps to meet the unique needs of the Hispanic community has also been the result of equitable distribution. Our

Bakersfield, Oxnard and East Los Angeles projects now employ nearly 300 Senior Aides, virtually all of them of Mexican descent. Many of these older workers are also bilingual and work as translators at homeless shelters, rape hot lines, legal service offices and health clinics. These Senior Aides staff child day care centers and after-school youth programs, permitting single mothers to get jobs instead of public assistance. They work in Alcohol and Drug Abuse projects, in literacy programs and, as trained teacher aides, help high school dropouts pass their GED exams.

In both of these cases of increasing employment opportunities and needed services in underserved communities——as in similar examples throughout the country——the State of California was fully informed of our efforts and pleased with the results. We do not see a need for additional statutory directives or bureaucratic steps to ensure progress toward equitable distribution. We have made great strides and will continue to do so wherever feasible. At the same time, we hope this Committee will concur with NCSC's position that no eligible, low-income senior, now gainfully employed in the program, should be laid off under this directive.

Bringing administrative costs to a minimum while maintaining a competent staff and assuring the integrity of the program has been a consistent objective among all the administrators of Title V. While we share the concern of the other sponsors that the impending 12 percent limit will create problems for some, we continue to take pride in an administrative rate that is projected at barely ten percent this year. We urge this Committee to continue to permit flexibility on the part of the Department of Labor, and believe a good deal of time would be saved in reviewing requests for exceptions if the administrative limit could be returned to 15 percent or, at the least, 13.5 percent. In this regard, we are especially concerned about those national contractors whose services are directed primarily toward minority groups. These sponsors do not have the economies of scale that NCSC and other large contractors have.

In the 1987 reauthorization, we urge the Committee to raise the current $5,111 average cost per enrollee. As you know, this unit cost per SCSEP worker has not been adjusted in five years, despite rising operating costs, Social Security payroll taxes and state minimum and prevailing wages. We believe that all Americans working at the minimum wage deserve a salary increase, and Title V senior workers--faced with escalating health care costs, rent, food and home energy bills--are no exception.

Today, more than ever, older workers need employment opportunities. Although increasing numbers of senior citizens want and need to reenter the labor force, long-term unemployment among workers 55 and over remains disproportionately high. A Congressional Research Service study, published last April on Displaced Older Workers, found that while workers 55 and over were 18.4 percent of all displaced workers, they represented just 11.3 percent of all displaced workers who had found new jobs. The study noted that "given their relatively high unemployment rate (31.8 percent), it appears that the 55-64 age range group had the most difficulty upon losing their jobs. Black workers in this age group, with an unemployment rate of 57.6 percent, seem to have had an especially hard time in the labor market."

As we have said, NCSC is particularly concerned that Older Americans Act programs are adequately targeted to low-income and minority seniors, as well as the growing frail elderly population. In the case of the Senior Community Service Employment Program, this service priority is already being addressed.

As the only means-tested program under the Act, all Title V workers have incomes below 125 percent of the poverty line, or $6,875, and 77 percent have incomes below the poverty line. Further, approximately 40 percent of NCSC Title V enrollees are minorities. Finally, more than half of all the older workers in the Program are employed in services assisting other older Americans.

The Title V senior jobs program remains the only major government response to the needs of older workers. Yet, this modest employment program enrolls less than one percent of an estimated eight to ten million seniors who are willing and able to work. Beginning July 1, 1987, Title V will return to its FY 1985 funding level of $326 million; sufficient funds to support approximately 63,800 part-time jobs. While all other programs under the Older Americans Act have, once again, received increases in appropriations this fiscal year, Title V funding has remained stagnant for some time.

Mr. Chairman, while some Federal programs may warrant significant structural or administrative adjustments to bring about improvement, in the case of Title V, we have a time-tested, successful program which has consistently proven its worth. Recognizing the vital need for this program and the tremendous contribution Title V workers are making in their communities, we urge this Committee to reauthorize Title V for a minimum of three years. Moreover, the National Council of Senior Citizens strongly recommends that the 1987 reauthorization of the Older Americans Act provide sufficient growth in the Title V program to afford more low-income older persons the opportunity to participate and remain productive and self-sufficient members of their communities.

Thank you.

Appendix A

Targeting of Older Americans Act Services

	1980*	1981	1982	1983	1984	1985
CONGREGATE MEALS						
Total # of Meals	127 m	143 m	140 m	145 m	147 m	150 m
Total # of Persons	3.1 m	2.8 m	2.8 m	3.2 m	2.9 m	2.9 m
Greatest Social Need	n/a	1.3 m (46%)	1.4 m (50%)	1.5 m (49%)	1.6 m (54%)	1.6 m (54%)
Greatest Economic Need	1.9 m (62%)	1.7 m (60%)	1.7 m (61%)	1.8 m (56%)	1.6 m (56%)	1.6 m (53%)
Minority	586,000 (19%)	535,000 (19%)	501,000 (18%)	591,000 (19%)	496,000 (17%)	475,000 (16%)
HOME-DELIVERED MEALS						
Total # of Meals	40 m	45 m	51 m	58 m	67 m	75.5 m
Total # of Persons		568,000	517,000	611,000	611,000	693,000
Greatest Social Need		361,000 (64%)	370,000 (72%)	390,000 (64%)	43[illegible],000 71%)	483,000 (69%)
Greatest Economic Need		372,000 (66%)	349,000 (67%)	370,000 (61%)	388,000 (63%)	447,000 (64%)
Minority		109,000 (19%)	103,000 (20%)	115,000 (19%)	114,000 (19%)	120,000 (17%)
SUPPORTIVE SERVICES						
Total # of Persons	9.3 m	8.9 m	9.1 m	9.2 m	9.1 m	9.3 m
Greatest Social Need	n/a	3.7 m (42%)	4.1 m (44%)	4.3 m (47%)	4.5 m (49%)	4.4 m (47%)
Greatest Economic Need	5.1 m (54%)	4.5 m (51%)	4.7 m (52%)	4.7 m (51%)	4.3 m (47%)	4.0 m (43%)
Minority	2.0 m (22%)	1.6 m (18%)	1.7 m (18%)	1.6 m (18%)	1.6 m (18%)	1.5 m (16%)

*Targeting figures for 1980 combine Congregate and Home-Delivered Meals; m= million.

Source: Administration on Aging, Summary of Program Performance

Senator Matsunaga. Thank you very much, Mr. Hutton.

We will be happy now to hear from—do you pronounce it Zobel or Zobel?

Ms. Zobel. Zobel.

Senator Matsunaga. Zobel. We would be happy to hear from you, Ms. Zobel.

Ms. Zobel. Thank you, Mr. Chairman. I apologize for Dr. Glasgow not being here today. He had an emergency and was unable to come. I am the national director of the Urban League's Title V program.

I thank you for the opportunity on behalf of the National Urban League to provide you with testimony today specifically on Title V. The Urban League has a long and distinguished history in combatting racial injustice and in securing employment opportunities for our poor and minority constituents.

Since 1978, Mr. Chairman, we have been a sponsor of a Title V program which we call the Seniors in Community Service Program, SCSP. This testimony substantiates the important role that Title V plays and should continue to play in providing low-income older adults with meaningful work experience, while helping them to meet the social service needs of local communities across our country.

In 1964, the National Urban League published a pioneering document entitled "Double Jeopardy: The Older Negro in America Today," which for the first time brought to the forefront the very special plight of black older Americans.

"Double Jeopardy" identified the fact that aging, low-income minorities suffered directly from the cumulative effects of a lifetime of depravation and injustice. Over 20 years later, because their incomes were consistently low and unstable, minority older adults today are eligible for only the smallest benefits as compared with many of their white counterparts. The bottom line is that far greater numbers of minority older adults enter their later years with severely inadequate financial resources.

Now, in its ninth year, the League's seniors program enables older adults to return to the labor force, to once again contribute through work.

SCSP operates through its affiliates in 27 local communities. During the past program year, SCSP provided employment opportunities to over 3,400 low-income individuals. An analysis of the participants enrolled in SCSP reveals that blacks and other minorities, who are statistically three times as likely to be poor, represented 81 percent of the population served by the Urban League; 51 percent had not completed high school and 73 percent were 60 years and older. Women, many of whom had little or no previous work experience, made up 71 percent of the enrollments.

SCSP participants serve their communities even beyond the scope of the employing agencies where they work. As program participants, and later as unsubsidized workers, these individuals earn an income, reduce their dependency on public entitlements, contribute to the tax and Social Security base, and purchase more goods and services.

In the last year, our participants, as well as our unsubsidized placements, combined, contributed close to $250,000 in Social Security taxes. In short, Title V is a boon, not a burden, to the national economy.

We successfully transition 627 participants, 31 percent of our allocated positions, into unsubsidized employment; and as a result of unsubsidized employment the average annual wage of our unsubsidized workers was $7,383. This represents an increase of $3,837 over the subsidized wage while in Title V.

Title V works, Mr. Chairman. It works for the program participants, for the community, and for its employers. The National Urban League, the State sponsors and the other national sponsors have been doing an excellent job in working together. The program is well managed, cost effective, and meets Congressional and Department of Labor objectives.

We have several recommendations, Mr. Chairman. The National Urban League recommends that sufficient funds be allocated to expand funds to the economically vulnerable; that the Chairman's bill, S. 887, extend the Older Americans Act for five years.

We recommend that additional language be added to section 502(E) which gives opportunities for suitable public and private employment to those who are poor and most in need. We recommend, Mr. Chairman, that the administrative cap be restored to 15 percent in order to more efficiently and effectively serve our constituents.

Lastly, Mr. Chairman, we recommend language to be inserted into the Act which disregards allowances, earnings and payment to Title V participants in determining their eligibility for subsidized housing.

Please enter our full written statement into the record, Mr. Chairman. Thank you for this opportunity.

Senator MATSUNAGA. Without objection, your full statement will appear in the record.

[The prepared statement of Mr. Glasgow follows:]

National Urban League, Inc.

Testimony of the

NATIONAL URBAN LEAGUE, INC.

Presented by

DOUGLAS G. GLASGOW

VICE PRESIDENT FOR WASHINGTON OPERATIONS

Before the

SUBCOMMITTEE ON AGING

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

On the

REAUTHORIZATION OF THE OLDER AMERICANS ACT

APRIL 30, 1987

Mr. Chairman and members of the Subcommittee, I am Douglas Glasgow, Vice President for Washington Operations of the National Urban League. The National Urban League (NUL) was founded in 1910 as a nonprofit community service organization committed to building bridges between white and black Americans, between private and nonprofit sectors, and between those who have resources and those who need them. There are currently 111 cities with Urban League affiliates located in 34 states and the District of Columbia.

On behalf of the National Urban League, I welcome the opportunity to provide testimony on the reauthorization of the Older Americans Act, and more specifically Title V. The Urban League has a long and distinguished history of combatting racial injustices and in securing employment and training opportunities for our poor and minority constituents. Since 1978, we have been a sponsor of a Title V program -- which we call the Seniors in Community Service Program (SCSP). This testimony substantiates the important role Title V plays -- and should continue to play -- in providing low-income older adults with meaningful work experience while helping to meet the social service needs of local communities across the country.

The problems of aging in our society have become, too frequently, burdensome, humiliating and perplexing for the poorest adult age group in America -- our senior citizens. Many of today's older adults are forced to live under social, economic and physical conditons for which they are unprepared and unaccustomed. Conditions for older minorities are much more severe; their rate of poverty is three times greater than the majority population.

Title V provides new and useful roles for older adults who would not otherwise have the opportunity to continue to participate in the work force. Title V provides viable alternatives to their inablity to find employment by virtue of their age, minority status, educational attainment and/or life experiences. Title V meets a wide variety of social, emotional as well as economic needs -- helping older workers to stay healthy and to maintain their independence, dignity and participation in the work force.

In 1964, the National Urban League published a pioneering document entitled DOUBLE JEOPARDY: The Older Negro in America Today, which for the first time, brought to the forefront the very special plight of black older Americans. Double Jeopardy identified the fact that aging low-income minorities suffered directly from the cumulative effects of a lifetime of deprivation and injustice. Limited schooling and pervasive racial discrimination ruled out opportunities for skilled jobs, steady employment and decent wages -- and those who were unable to gain skilled jobs were paid far less than their white counterparts.

And over twenty years later, because their incomes were consistently low and unstable, minority older adults today are eligible for only the smallest Social Security or pension benefits, if any. The bottom line is that far greater numbers of minority older adults enter their later years with severely inadequate financial resources. In fact, according to a 1987 report issued by the Villers Foundation, 31.5% of the black elderly are in poverty, as compared to 11% of elderly whites. Older minorities need employment opportunities not simply to alleviate boredom -- they need employment opportunities because they need the income to survive; they want to work, and they want to be contributing members of their communities.

Now in its ninth year, the National Urban League's Seniors in Community Service Program (SCSP) enables low-income older adults to return to the labor force -- to once again contribute through work. Participants work twenty hours a week in subsidized community service jobs while preparing to transition into unsubsidized employment. SCSP operates through its affiliate Urban Leagues in 27 local communities.

There are three key groups of beneficiaries of SCSP: the participants, low-income adults age 55 and over; the community-at-large, represented by the employing agencies where the participants work at subsidized wages providing a variety of sorely needed services to community citizens; and the employers who ultimately enjoy the rewards of hiring our productive, dependable, job-ready clients in unsubsidized jobs.

During the last program year, ending June 1986, NUL-SCSP provided employment opportunities to 3,476 low-income individuals. An analysis of the participants enrolled in NUL-SCSP at the end of the 1986 program year reveals that 84% were at or below the poverty level. Blacks and other minorities, who are statistically three times as likely to be poor as their white counterparts, represented 81% of the population served by SCSP. Fifty-one percent (51%) of the participants had not completed high school and 73% were 60 years and older. Women, many of whom had little or no previous work experience, made up 71% of the enrollments.

SCSP participants derive a broad spectrum of services and benefits from the program, which include:

--Wages and fringe benefits which improve their standard of living.

--Active involvement in their communities through meaningful work which contributes a wide range of services to a variety of age groups.

--A structured "employability" (job readiness) training program, along with skills training and access to educational programs as needed.

--Personal and job-related counselling on an individual and group basis.

--Annual physical examinations.

--Transportation arrangements, when necessary, to and from work and to other program activities.

--Assistance in obtaining work tools and uniforms, when necessary.

--Information and referral on public benefits, legal assistance, consumer rights, etc.

--Access to permanent, unsubsidized jobs and follow-up assistance.

--Renewed confidence and self-respect as valuable workers.

More than 550 public and private community service agencies in 27 communities employ NUL-SCSP participants in jobs each year. A wide variety of institutions are served by SCSP workers, including hospitals, day care centers, libraries, schools, local government agencies, etc.

Title V participants are not assigned "make work" jobs.

--At a Boston city hospital, a participant is working as a pediatric assistant in a ward for children who are abandoned and drug-afflicted.

--Participants in Philadelphia assist therapists in working with handicapped children at the Community Development Child Care Center.

--In Columbus, OH, participants have received first aid training with the American Red Cross and serve in internships as blood technicians.

These agencies need Title V services now more than ever before, given severe cutbacks in public funding that are squeezing social service agency budgets. Employing agencies depend on the invaluable contributions that the SCSP participants make toward the smooth functioning of their operations.

Most SCSP participant job duties are directly involved with services to other needy members of their own communities. While emphasis is placed on providing services to a cross-section of the total community, over one-third (37%) of the services are targeted specifically to the elderly community through employment with nursing homes, nutrition programs, senior centers, municipal aging offices, etc.

The ultimate beneficiaries of Title V services are the clients of the employing agencies. They are the neediest members of the community, who have endured cuts in a variety of social services on which they depend, and therefore need the services of Title V workers now more than ever before. From the homemaker who sees to it that a homebound invalid gets a hot meal, to the Day Care Assistant who makes it possible for a mother to work and earn a living full-time, all Title V workers are making a direct and measurable impact on the lives of their fellow citizens.

Employing agency supervisors typically report that Title V workers are among the most reliable, most punctual, trainable and productive employees they have. Some agencies have ultimately hired SCSP participants in permanent positions. Most, however, are not in a financial position to do so, and they frequently lose valuable Title V workers to employers who are able to offer participants unsubsidized positions.

SCSP participants serve their communities even beyond the scope of their employing agency functions. As program participants and later as unsubsidized workers, these individuals earn an income; reduce their dependency on public entitlements; contribute to the tax and social security base; and purchase more goods and services. In the last program year, NUL-SCSP participants and unsubsidized placements combined contributed close to a quarter of a million dollars in social security taxes. In short, Title V is a boon, not a burden, to the national economy.

In the last program year, SCSP successfully transitioned 627 participants, 31% of our allocated positions, into unsubsidized employment. Of these participants, 83% were minorities. Females represented 60% of the unsubsidized placement population, while their participation rate in SCSP was 71%. A majority, 54% of the transitioned participants had not completed high school, and over three-quarters (78%) were under 65 years of age. Only 9% of the transitioned participants were 70 years or older while their participation rate in the program was double, at 19%. These statistics are an indication of the general attitude employers have toward the hiring of older workers and females.

As a result of unsubsidized placement, it is estimated that NUL-SCSP participants receive annualized wages of over $4.6 million. Although representing only 58% of the total unsubsidized placements, full-time jobs accounted for over 73% of the total estimated annualized wages. The average annualized wage for the 627 transitioned older workers was $7,383. This represents an increase of $3,837 over their annualized subsidized wages while participating in the Title V program.

Title V works -- it works for the program participants, it works for the community, and it works for employers. Title V works because:

--National and state sponsors have excellent working relationships -- we coordinate our program services and activities; assess local community needs; and work closely together to meet the objective of equitable distribution within each state, assuring that those most in need are enrolled in the program.

--The program is well-managed, cost effective and meets Congressional and Department of Labor objectives.

--The program provides flexibility, allowing each sponsor to deliver orientation, training, subsidized work experience and support services to participants in a manner most effective for each sponsoring organization.

--Program sponsors access other available community resources for the participants, e.g., training through JTPA, community colleges, and vocational and technical institutions.

CONCERNS AND RECOMMENDATIONS FOR REAUTHORIZATION:

- Title V serves less than one percent of the eligible senior population. NUL recommends that sufficient funds be authorized to expand services to minority and other poor older adults, those who are most economically vulnerable.

- Program planning is a key element in the effective administration of Title V. NUL supports the Chairman's Bill S887 to extend the Older Americans Act five years. This certainly will lend greater stability to the program, a program that has proven its worth to the entire country, and to the citizens and communities it serves.

- To better assure targeting of services within each state to those with the greatest economic need, NUL recommends that the statute reinsert the following to replace the current Section 502(E), "will provide employment for eligible individuals whose opportunities for other suitable public or private paid employment are poor."

- The administrative limitation for Title V was reduced from 15% to 13.5% this program year, with another reduction to 12% effective July 1987. As a result of the initial reduction in the administrative cap the NUL was forced to reduce staff and technical assistance support to its projects. In order to assure that Title V continues to maintain its high standards of effective management and services to older adults, and the community, NUL recommends that the administrative cap be restored to 15%, as provided for in JTPA employment and training programs.

- Over the last six years the average enrollee unit cost has remained at $5,111 while the costs for services and benefits to program participants have increased. There have also been added responsibilities assigned by the Department of Labor to Title V sponsors -- an increase in the unsubsidized placement goal, emphasis on private sector initiatives, and additional administrative burdens such as independent external audits, and increasing requests for coordination with other agencies. Therefore, the NUL recommends that the enrollee unit cost be adjusted annually to reflect increases in responsibilities and necessary operating expenses to the Title V sponsors.

- Approximately 16% of the NUL-SCSP participants reside in government subsidized housing. Their training wages while in Title V training are now considered earnings in determining their monthly rent charges. As a result, many of these participants have terminated themselves from the program, becoming once again -- more economically vulnerable, socially isolated, and left with a sense of hopelessness. In the interest of assuring that poor older workers, those who in many cases need Title V the most, can reap the benefits of the program, the NUL recommends that language be added to Title V of the Older Americans Act which disregards allowances, earnings and payments to individuals in Title V in determining eligibility for any federal or federally assisted programs, similar to JTPA, Section 142(b).

In closing Mr. Chairman and Subcommittee members, I would like to state that Title V is a vital program which has earned unprecedented bipartisan support. Minorities and other poor older adults have been hardest hit by cuts in social service programs. Data show that there has been a decline of 25% in the numbers of minorities served by senior citizen centers and close to a 15% decline in minorities served by nutrition programs. As you consider your reauthorization Mr. Chairman, please give serious consideration and priority to strengthening and expanding the programs under the Older Americans Act which will equitably serve older Americans in most economic need.

Thank you again for the opportunity to present our comments at the Subcommittee hearing today. We request that our full written statement be entered for the record.

Senator MATSUNAGA. Now, we would be happy to hear from a former Congressman, my good friend and former colleague in the House, Alec Olson. Nice to see you, Alec.

Mr. OLSON. Thank you, Mr. Chairman. Might I say that as I was sitting here this afternoon I was reminded that I have not had a good pineapple since you used to bring me one once in a while.

Senator MATSUNAGA. You should have continued running for the House, if not for the Senate. [Laughter.]

Mr. OLSON. Mr. Chairman, I am here this afternoon to, of course, join with my colleagues and, in fact, join the overall support that has been given Title V by any and all witnesses that I have heard here today and any that I have heard mention Title V in previous testimony.

The Senior Community Service Employment Act was not a part of the Older Americans Act from the very outset, as you are aware. It came about as a demonstration project authorized by an amendment offered in the United States Senate to the Economic Opportunity Act, where a demonstration project could, in fact, put older Americans to work at beautification projects. Of course, it was very successful and has expanded since that time.

Very frankly, 20 years ago we did not recognize as we do today the need for job opportunities and employment of older Americans, and the foresight of that opportunity being made available at that time, is evident to all today. Millions of older Americans do not have the means to retire and provide for the increased cost of services, as have been discussed here today.

So we feel in Title V that this program has been and is a program without equal, demonstrating what is a very vital and growing need for older Americans.

The opportunity to administer a program that is as well written and as well directed by its regulations is not often, in my estimation, available. As a result of those regulations, Green Thumb, enrolling the most needy find that over 30 percent of our enrollment is 70 years of age and older.

We find that when serving the most needy, it follows automatically that we enroll minorities in greater proportion than is true of the population of the area that they represent.

For instance, in Colorado 22 percent of our enrollment is Hispanic. The State average is about 12 percent. In Montana, we enroll ten percent native Americans; the percentage of the population is less than five. In Baltimore City, our enrollment is 82 percent black.

I could go on and on with illustrations of the fact that when administering the program as directed by the regulations we are serving the most needy persons, and that the need is such that we have never have problems of recruitment and enrollment.

There have been enrollment problems in programs like the three-percent set-aside in JTPA, and I am not critical at all. They are newer, they are growing in their ability, to spend their funds and serve the population that is targeted.

I would rush along here in view of the hour and your patience and this being a long hearing to emphasize one point that Green Thumb thinks would enable a more efficient administration of our particular project, not speaking for anyone else, and that is that the in-kind requirement is simply a large paper transaction as far as Green Thumb is concerned.

We are not advocating the elimination of in-kind; we are simply pointing out that the law not require the paperwork, and the statement does point that out, I hope, adequately, that it is automatic. We have host agencies, over 10,000 of them, in over 1,900 counties and they must provide the support for enrollees assigned them that more than adaquately meets in-kind requirements.

In fact, the regulations require, and we, of course, monitor and require that that supervision is provided by the host agency. We feel if the host agency has any wherewithal, and particularly cash, to make in contribution, they should hire the enrollee. We require that they supervise the job duties that they assign, and do it well.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Olson follows:]

STATEMENT
of
ALEC. G. OLSON, ADMINISTRATOR
GREEN THUMB, INC.
to
SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
regarding

REAUTHORIZATION OF THE OLDER AMERICANS ACT

April 30, 1987

Mr. Chairman:

I appreciate the invitation to appear before you today. I am Alec G. Olson, Administrator of Green Thumb, Inc., a not for profit corporation organized in 1965 to demonstrate that unemployed, low income older persons that needed jobs could and would provide added services to the community in which they lived, while in most cases escaping poverty. Early success brought expansion of the effort which today is recognized as the Senior Community Service Employment Program (SCSEP) authorized by Title V of the Older Americans Act.

Green Thumb's first grant, signed December 21, 1965 to employ older workers, was made possible by an amendment offered in the United States Senate to the Act establishing the Office of Economic Opportunity. The significance of the first federally funded jobs program for older Americans is that it came at a time long before the demographics were clear, as they are today, in regard to the usefullness of older workers and older worker needs for meaningful work as well as for income.

By 1990, 44% fewer 18-to-25 year-olds will be entering the workforce than entered it in 1979, according to a recent issue of Prentice-Hall's Policies and Practices. By contrast, between now and the year 2000, 33 million people ages 50-54 will be approaching what is now considered expected retirement age and ten years later, 70 million people -- 25% of the population -- will be over 55, and 35 million will be over 65 years of age. It was with these contrasting demographics that Harold Johnson, senior vice president of personnel administration at The Travelers, (Hartford, Conn.) introduced his remarks on the vital role older workers can and want to play in the workforce.

In 1965, Congress and the Administration were convinced they should support and lead in an effort to demonstrate that the basic need to work does indeed include older Americans. In 1987 no argument needs to be made for older Americans' participation in the work force. Rather, we are examining effective ways to assure this result. While Travelers has pioneered the use of their retirees to supplement and reinforce their staff, the Senior Community Service Employment Program has been blazing trails in helping economically disadvantaged older people who have fallen out of the labor market get back on the ladder.

The Senior Community Service Employment Program is targeted to those over 55 years of age, with incomes below 125% of poverty who have poor employment prospects. They are provided the opportunity to work part-time with host agencies to contribute to the general welfare of their community. That mandate has been expanded over the years to increase efforts for training and placement into unsubsidized employment and endeavor to distribute the employment opportunities equitably across a state to reflect the residence of eligible individuals.

The question to be answered is this: does the Senior Community Service Employment Program contribute effectively to expanding employment opportunities for older men and women who need and want to enter the work force?

Twenty years ago, retirement was the goal for older persons; those without the means to retire were not recognized as good employee prospects. Even though the Senior Community Service Employment Program benefits directly only a small number of our targeted group, the program has served to dispell myths and barriers to employment of older Americans in virtually every community in our country.

More important, this program began and continues to focus on the most disadvantaged older persons, namely persons over the age of 60. When I speak of the disadvantaged, I am reminded of a quote that appeared recently in the Health Supplement of the Washington Post: "Lumping all older people together is about as useful as grouping mallards and mosquitoes because both have wings."

Title V of the Older Americans Act is directed to the employment needs of older Americans and specifically to persons qualifying because of low income. The Department of Labor regulations have directed the enrollment criteria of need and the priority of age 60 plus to the degree necessary to assure that the Senior Community Service Employment Program accomplishes its purpose. When the enrollment priorities are met, the results speak for themselves.

I want to share with you results in Green Thumb's program that I believe demonstrate effectively the distribution of resources that are quite limited when compared to need.

Green Thumb's recruitment in the over 1900 rural counties represented in our Title V project is the keystone of our project. If we were not activists in our recruitment, I do not believe our enrollment would contain as large a number of enrollees over the age of 70 as it does. Currently over 30% of Green Thumb's 18,419 enrollees are age 70 or over.

If we did not seek the neediest, our enrollment of Native Americans would not exceed 12% of the Green Thumb workers in Oklahoma, and 10% in Montana, or 22% Hispanic enrollment in Colorado. If we did not seek the neediest in Baltimore, Maryland, our enrollment in that city would not be 82% Black.

In the truest sense, the most needy older Americans are the minorities for purposes of Title V of the Older Americans Act. In many rural communities, white older Americans who are income eligible are the only minority to be served.

We have little difficulty finding community subsidized service jobs for our enrollees. Green Thumb enrollees want to work and their host agencies testify that they do work. Small towns, villages and rural counties are often hard pressed to find local tax income to finance needed community services. Limited or nonexistent public transportation increases the cost and complexity of delivering those services. Non-profit host agencies also find greater need for help than their resources can provide. So the willing hands of Green Thumb workers multiply the efforts of their own staff.

Still, age discrimination and limited job opportunities, especially in rural communities, impede unsubsidized placement. The present economic crisis suffered by farmers and the small towns that supply their needs have forced Main Street businesses to close and decreased the support for local schools, hospitals, nursing homes and churches.

As the older worker program has grown and developed over the years, Congress and the Department of Labor have called for greater emphasis on training and placement of Title V enrollees in unsubdized employment. And we agree that an unsubsidized job beats a subsidized one because it most often offers permanent employment with more hours and better pay than the part-time minimum wage job in SCSEP, although that one most often opens the door. Most of our placements are with host agencies, because through demonstration of abilities, age discrimination as a consideration in their employment is to a large extent removed. The value of helping people find a job is recorded in the many appreciative letters we receive from those enrollees and former enrollees who have been assisted in finding unsubsidized jobs -- and from their satisfied employers.

Green Thumb is encouraged that we are increasingly successful in better serving the employment needs of older Americans through coordinating efforts with other jobs programs.

Coordination with the Job Training Partnership Act is growing and, though we do not seek direct responsibility for JTPA's 3% set-aside for older workers, we do administer that effort in the State of South Dakota. The most recent report on their Job Training Partnership Act program entitled "The Partnership that Works" referred to that effort: "In providing services to South Dakota's older workers, Green Thumb, Inc. concentrated its efforts on meeting special needs of older workers. The future for employment of the older worker in South Dakota looks bright as the partnership between the Department of Labor and Green Thumb, Inc. grows."

Our work with the service delivery areas and private industry councils of JTPA and the use of on-the-job training contracts as part of the special experimental program under Title V are helping us build a stronger working relationship with the private sector where more unsubsidized jobs are available than in the non-profit and public sectors where we originally work in placing enrollees in community service jobs.

We will build on those contacts as an aid to making more jobs available for older workers.

Mr. Chairman, these comments have risked the assumption that you and your colleagues have ample knowledge of the need for the Community Service Employment Program and would be best served by my sharing results of the program.

I have but one suggestion that I am firmly convinced would result in improving administration of the program.

The law as it exists requires "in-kind" contributions, and records must be kept to document these contributions. I do not suggest elimination of in-kind contributions but rather point out that the program automatically includes required in-kind.

Enrollees placed in community service jobs require the same training, direction and supervision required by a host agency's other employees. Satisfaction of that fact, however, is not sufficient for the administrators of projects under Title V, for to meet the law's requirement, we must document the host agency activity. To satisfy audit requirements, Green Thumb must request each host agency to document their supervision and/or any additional contributions for each enrollee for each pay period. The cost of the forms alone is in the neighborhood of $20,000 a year. If we ask each of our over 10,000 host agencies to supply this information on their own forms, it would be an accountant's and auditor's nightmare!

The staff hours we dedicate to this function contribute the least, in fact in my estimation, nothing to our project since nothing would change if this requirement did not exist.

A very closely related possible additional problem has surfaced in an assertion by some that host agency supervisors are employees of Green Thumb, Inc. while supervising enrollees placed in their agency by Green Thumb.

I am sure it was not Congress' intention to place a non-productive burden on administrators of the SCSEP; so, I believe, removing the in-kind reporting requirement merits your consideration.

While the number of older Americans living in poverty has decreased from over 30% a quarter century ago to 12.6% in 1985, still 3.5 million elderly persons were living below the poverty level in 1985 and another 2.3 million had incomes between poverty level and 125% of poverty, the income guideline for Title V. Over 18% of the people living in rural areas (outside Metropolitan areas) were living in poverty in 1983, according to Current Population Reports published in Family Economic Review of the U.S. Department of Agriculture and supplied by the Bureau of the Census. I believe this underlines the need for continued expansion of Title V of the Older Americans Act.

I also want to make the point that the happiest people I meet, and the healthiest people I meet among older, low income persons are the enrollees of Green Thumb. They are healthy because they are working. I know, and you know, without reading any studies, that is the way to keep people involved, active and interested in their communities. Proportionate to Title V's resources, I believe it contributes enormously to healthier, happier, economically better off older Americans, both for those served by and those enrolled in the program.

I believe this program meets and, I hope it exceeds, your expectations and deserves reauthorization.

Thank you.

Senator **Matsunaga**. Thank you very much, Alec.

Now, unless any of you feel that you need 15 seconds more to feel that you have made a worthy trip to Washington, I will be closing this hearing.

Perhaps for the record, Mr. Hutton, you would like to present your aide.

Mr. **Hutton**. Yes, I would love to. This is Mr. Ernest Post, formerly of the United Steelworkers of America, who for the past four years has been my deputy handling the Senior AIDES Program, we are very proud to say.

Senator **Matsunaga**. Fine. The record will show his presence as an able aide, spelled a-i-d-e. [Laughter.]

Mr. **Hutton**. He is alert, industrious, dependable and energetic, Mr. Chairman.

Senator **Matsunaga**. Thank you very much, all of you, for appearing before the Subcommittee.

We have a statement here from Senator Hatch, whose statement will appear in the record immediately following mine.

[Additional material supplied for the record follows:]

National
Association of
Regional
Councils

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TESTIMONY OF

JONATHAN B. HOWES

PRESIDENT, NATIONAL ASSOCIATION OF REGIONAL COUNCILS

BEFORE THE

SUBCOMMITTEE ON AGING

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

THE HONORABLE SPARK M. MATSUNAGA, CHAIRMAN

ON

REAUTHORIZATION OF THE OLDER AMERICANS ACT OF 1965

April 30, 1987

Washington, D.C.

Mr. Chairman, I am Jonathan B. Howes, President of the National Association of Regional Councils (NARC). In addition to my duties as President of NARC, I am a Councilman from the Town of Chapel Hill, North Carolina and a member of the Triangle J Council of Governments, located in Research Triangle Park, North Carolina.

NARC appreciates the opportunity to submit the following testimony on reauthorization of the Older Americans Act of 1965. The existing aging network of area agencies and state units on aging is well suited to continue to offer community based services to the nation's growing elderly population. Moreover, we feel that regional councils (working as AAA's) should continue as a vital element in the aging network. In short Mr. Chairman, we appreciate your leadership in recognizing the distinctive roles that state and local governments play elderly service delivery.

Regional Councils as Area Agencies on Aging

With the passage of the Older Americans Act in 1965, many states and/or localities decided to place the AAA function in regional councils. 187 of the 600 area agencies on aging operate under the umbrella of regional councils and these include a broad cross-section of both rural and metropolitan regions. In several states, regional councils, while not serving as AAAs, were utilized to establish the mechanism for the AAA's function.

Regional councils have been effective in responding to service mandates under the Older Americans Act within the limits of the resources provided to do the job. Their approach to services, in terms of emphasis and packaging, has differed depending on local conditions, needs and desires. The direction in recent years has been toward provision of a wide spectrum of services. Greater efforts are being made to identify the most vulnerable (frail and minority) individuals within the elderly population and provide outreach services. The degree of state policy and administrative support has been a key factor in determining the effectiveness of respective regional council aging programs.

Regional councils operating aging programs have traditionally enjoyed a high degree of support among local elected officials and the elderly. Part of the reason for this broad-based support is the unique ability of regional councils to bring into the aging program planning and development process many municipal officials not ordinarily involved in human service programs. The human services field has traditionally been the province of state and county welfare agencies. The involvement of local elected officials and broad-based advisory committees established by the councils has payed handsome dividends in terms of additional matching funds and valuable in-kind services.

The regional planning process and areawide clearinghouse function under E.O. 12372 enables local elected officials to coordinate their actions in a wide range of program areas that impact the elderly. For example, regional councils that are designated regional planning agencies under federal transportation legislation are able to integrate the special transportation needs of the elderly into their model transportation plans for their area. Councils have also been instrumental in efforts to incorporate aging programs concerns into manpower planning activities under the Job Training Partnership Act.

The advantages of housing an area agency within a regional council are numerous. Area Agency staff can draw on the expertise of other professionals and resources not ordinarily found in most single-purpose agencies (e.g. legal contracts, regional data collection and processing, engineering, and program and fiscal management). Many regional councils are repositories for census and other data with expanded capacity to analyze and aggregate it. Councils also have vast experience in competitive bidding (through joint purchasing programs for local governments) and performance contracting.

Across the country, local elected officials are very supportive of the role for regional councils in programs under the umbrella of the Older Americans Act. The strong linkage that exists between local elected officials and local governments they represent on regional council boards builds a public accountability factor that is not typically found in most single-purpose or nonprofit institutions.

Recommendations for Changes in the Older Americans Act of 1965

In February, the NARC Board of Directors met in conjunction with our annual Washington Policy Conference. At that meeting the Board unanimously approved a set of policies on reauthorization of the Older Americans Act. A summary of those policies follows.

NARC urges that Congress reauthorize the Older Americans Act of 1965 in order to continue the current system of home and community based care for our nation's growing elderly population. The changes that we recommend in this document are intended to be only to be minor changes in the law. As an association, we believe that the existing structure has been effective in serving the needs of older Americans.

The Aging Network

NARC believes strongly that the existing network on aging of Area Agencies and State Units on Aging is a proven framework for serving the nation's elderly as it covers the entire country. Attempts to improve the family and community based system of services for older Americans should be done within the context of this network.

Regional Councils as Area Agencies (AAA)

NARC reaffirms its position that regional councils be given preference in administering aging programs with the concurrence of local government. Accordingly, NARC strongly opposes any policy "favoring" the designation of single-purpose organizations and/or other nonprofit organizations.

Scope and Focus of Functions

Congress should authorize and fund programs under the Older Americans Act that provide support for alternatives to institutionalization for the elderly. Moreover, the Act should continue to support the Area Agency as the primary planning and service delivery mechanism for the vulnerable elderly under the Older Americans Act. In addition, emphasis should be given to encouraging Social Service Block ~~Grants,~~ Medicaid, Medicare as well as state and local revenues to be integrated into the program through case management and other related activities.

NARC endorses a reauthorization of the Older Americans Act of 1965 which includes and adds provisions for additional administrative flexibility, increased program authorizations, continued emphasis on services to functionally impaired, minority and low-income elderly and authority to initiate efforts to coordinate community-based long-term care services.

Status of AOA within HHS

NARC urges an upgrading of the Administration on Aging within the Department of Health and Human Services. An Assistant Secretary for Aging should be established to represent the interests of all older Americans within the Department of Health and Human Services.

Targeting

NARC supports language within the Act which gives preference for services to older individuals with the greatest economic and social needs, with particular attention given to low income and minority individuals.

During its 1987 reauthorization of the Older Americans Act, NARC recommends that Congress consider the following changes:

- Flexibility -- Area Agencies should be given greater flexibility and discretion to enable them to develop more comprehensive and coordinated service delivery systems, and more effectively target the most vulnerable elderly in their communities.
- Priority Services -- Congress should grant maximum discretion to Area Agencies to determine priority services in their geographic areas based on Area Agency and intrastate differences.

- Increased Demands on Home Based Care -- The Older Americans Act should not supplement Medicare through Home Care and support services without additional new funds consistent with new demands on the system. NARC recommends that Congress consider transferring a minimum of 1 percent of the savings from Medicare cost containment measures (such as DRG's) to home and supportive services administered under the Act.
- Case Management -- Client centered case management systems should be used as the optimal means to avoid costly and unnecessary institutionalization. Functional assessments should be used to determine the needs for services within the community.
- Resource and Program Development -- Make both resource and program development a key function of Area Agencies and an allowable cost for those seeking additional support for needed services.
- Ombudsman and Quality Assurance -- With the growing elderly population living longer and with the Medicare system returning them home sooner, more elderly are receiving home-based care from the aging network fostered under the Act. However, the federal government has reduced its regulatory responsibility for in-home care and institutional care when the system needs greater accountability. NARC, therefore, urges that the long term care ombudsman program become a separate subsection of Title III with a separate authorization of appropriations providing additional funds. Moreover, Ombudsmen should be granted limited immunity from civil suits and protected from the impact of OMB A-122.

- Liability -- In response to the liability crisis facing all levels of local government, NARC endorses the inclusion of statutory language limiting the liability of Area Agencies on Aging.
- Title V -- The Title V (The Senior Citizens Employment Program) of the Older Americans Act should be administered by the same network as are other programs authorized by the Act.
- Administration -- Increase the area agency administration share from 8.5 percent to 11 percent to implement coordination mandates.
- Voluntary Contributions -- Allow local development of a sliding scale for recommended voluntary contributions.

Long-Term Care for the Elderly

Regional councils, as area agencies on aging, should play a lead role in developing a continuum of community based long-term care services that will enable the elderly to live independent lives within their home communities. NARC supports changes in the Older Americans Act and other legislation relating to the elderly that would place more emphasis on the development of long-term care services which incorporate the following principles:

- Emphasis on local needs and involvement of local elected officials in the planning and management of aging programs. The regional council structure offers significant advantages for the development of long-term care systems. These include strong ties to local elected officials, accountability, planning and assessment skills, and low administrative costs.
- The extent of local case management should be negotiated and determined at the local level and not mandated by federal legislation.

Case management can be an important tool in making the most effective use of available resources and is a legitimate activity for regional councils. However, the impact of case management is presently limited by the scarcity of alternatives to institutionalization in most regions.

- Stronger planning and coordination authority should be given to regional councils as area agencies on aging to develop community based long-term care systems. Progress in developing support systems for community based independent living arrangements will depend a great deal on the response of service providers and policy authorities outside the area agency on aging network.
- An intergovernmental partnership is required to develop effective community based long-term care systems. The federal government must continue its financial support, at least at current levels. States must pass legislation establishing community care systems, recognizing and supporting the role of regional councils in the development and implementation of such systems.
- Additional resources will be needed to implement a long-term care system if cuts are to be avoided in current aging programs.

Title IV

NARC supports channeling Title IV Discretionary Training, Research and Demonstration funds to Area Agencies to strengthen the aging network's ability to serve the needs of the elderly, and respond to community needs and priorities.

To the maximum extent feasible, local governments should be given flexibility in the design and implementation of programs under the Older Americans Act with regulations governing these programs based upon performance standards rather than federally mandated levels of program activity.

Single Administrative Unit at the State Level

NARC urges Congress to support regulations governing the Older Americans Act which continue support for a single administrative unit at the state level with responsibility for aging programs. This unit should, as is currently the case, seek input from area agencies in developing a state plan. Regulations should also continue to require a uniform funding formula for area agencies on aging. Provisions describing the type of agencies that may be designated as area agencies on aging should not be removed in any revision of the regulations, nor should these regulations eliminate staffing requirements at the area level. Finally, where the state must designate an area agency, regulations should prescribe a reasonable period of time in which this designation should be made.

First Right of Refusal

NARC urges that the present system of Area Agencies on Aging designated by AOA be maintained unless demographic and population shifts justify a review of existing boundaries. In such cases, a local governmental unit's first right of refusal shall apply only if the following criteria apply:

- A local government can demonstrate that it continues to fund services commensurate to meet the needs of the elderly poor residing within that local government's jurisdiction, based on the most recent census data figures.
- A local government's boundaries are reasonably contiguous to those of the area agency on aging (single jurisdiction) under existing state designated boundaries.
- A state shows that it has carried out provisions included in the federal regulations governing the designation of planning and service areas, designation of area agencies, withdrawal of area agency designation and continuity of services.

In multijurisdictional areas where a local government is not eligible for first right of refusal, where there is a need to improve accountability to local elected officials, regional councils which represent all local governments should be given preference in administering aging programs unless state law provides otherwise.

Mr. Chairman, members of the Subcommittee, NARC appreciates the opportunity to participate in these hearings leading up to eventual reauthorization of the Older Americans Act. We endorse your commitment to improving the system of community based care for our growing elderly population. If there is any assistance we can offer, please do not hesitate to call on us.

**NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE**

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STATEMENT OF
FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN OF THE NATIONAL COMMITTEE
TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO
THE COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON AGING
U.S. SENATE
REGARDING
OLDER AMERICANS ACT REAUTHORIZATION

APRIL 30, 1987

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four million members. Most of our members, age 60 and over, are benefactors or potential benefactors of programs authorized under the Older Americans Act. I, therefore, appreciate the opportunity to express the views of the National Committee on the reauthorization of the Older Americans Act.

"...in keeping with the traditional American concept of the inherent dignity of the individual..." the Older Americans Act states that seniors should have equal opportunity to adequate income; the best possible physical and mental health that science can make available without regard to income; adequate housing; restorative institutional care; a comprehensive array of community services; employment without discrimination; healthy, dignified retirement with access to worthwhile activities; efficient community services including low-cost transportation; benefit from new, proven research; and, finally, the freedom and independence to manage and plan their own lives.

This is a large mandate for a program with only one billion dollars in appropriations. Still the Older Americans Act has been highly successful in enhancing the lives of more than nine million seniors across the country every year. It has been highly successful because the Older Americans Act has been a catalyst for the development and coordination of services that meet the needs of senior citizens. To do this, advocacy has been at the core of the Older Americans Act.

New Administrative restrictions, low institutional status and lack of funding have reduced the ability of the Older Americans Act to serve as the advocate which Congress intended. Funding limitations have had an extremely negative impact on key aspects of the advocacy provisions of the act such as the nursing home ombudsman program, legal assistance and outreach and referral. Meeting the demand for current services, leaves few resources to develop innovative new programs, such as respite care.

The National Committee urges this Congress to clarify and strengthen the role of the Older Americans Act as an advocate for today's senior citizens and to adequately fund its innovative mission.

Advocacy: Clarify Guidelines

From the beginning, the Older Americans Act was designed to provide services to seniors not adequately served by other public and private programs. Perhaps even more important, the mandate was to advocate at the Federal, state and local level to encourage a more responsive attitude to the needs of older people.

The current Administration has tried to place a rein on advocacy under the Act. A few years ago, the Office of Management and Budget issued a ruling, the so-called A-122 Circular, which restricted organizations receiving Federal funding from interacting with legislative bodies. This rule clearly conflicts with the mandate of the Older Americans Act, and yet it reportedly has placed a damper on advocacy efforts by people working under the Act. Whether advocating for older Americans in the community or in institutions, it is important that the people doing the advocating have clear guidelines about what they can and cannot do. This confusion is unfortunate and should be cleared up once and for all with appropriate language in the authorization legislation.

Advocacy: Raise Status of Commissioner

The Older Americans Act provides for advocacy on behalf of senior citizens within the Federal government as well. The Federal Council on Aging is responsible for reporting to the President on aging-related matters. The Administration on Aging, headed by the Commissioner, runs most programs under the Older Americans Act. Many have criticized the Council and the Commissioner over the years for not being stronger advocates for seniors. At the same time, the Commissioner has only minor status within the Department of Health and Human Services. For years the idea of raising the Commissioner's position to the level of Assistant Secretary has been suggested. We support this proposal because it would give the job more visibility and more authority, reduce red tape, and could permit the Administration on Aging to function as a stronger, more viable advocate for seniors in this country.

Advocacy: Funding

The National Committee supports an increase in the authorization level of the Older Americans Act of at least five percent in each of the reauthorized years. The need is even greater, but Congressional appropriations are only 85 percent of authorized levels.

We would urge Congress not to consider the Administration's proposal for a "generic appropriation" approach to the Older Americans Act. It would pit human service providers against each other in their efforts to lobby for funds for their programs. The competition will be stiff because the overall funding for these programs will total $69 million less than they are currently receiving. Furthermore, it will reduce Congressional control over spending while giving the Administration greater leverage to force program managers to "play ball" in administering programs and advocating for more funding.

Advocacy: Outreach and Referral

An important function of the area agency is to inform seniors about available resources. Knowledge of a service is the first step in utilization. This is done through telephone information and referral services and through outreach into the community. Outreach has not received enough emphasis in the last few years because of scarce resources and because of the fear that too much publicity will bring too high utilization of already limited services.

Outreach should not be neglected, however. It is important for seniors to be aware of the existence of the area agencies so that they will know where to turn should they need services. A recent Louis Harris survey of senior citizens living alone found that sixty percent of respondents could not name an organization to which they might turn if they needed help. The same study also found that almost half of the poor seniors potentially eligible for Supplemental Security Income (SSI) had never even heard of the program. Although it is not solely the responsibility of the area agencies to provide information about the SSI program, it does indicate the serious need for more outreach to the older population. This component should be strengthened if not in the Act itself, certainly in the report language.

Advocacy: The Need for More Long-Term Care Services

Home Care. There is a documented need for more in-home care. Not only do seniors released from the hospital earlier require more intensive care in the home, but the older, more frail population with chronic conditions also requires assistance. The need is constantly growing as the population ages. By the turn of the century we can expect the aging population to have grown by 27 percent -- to make up 17 percent of the total population. Two proposals in the House would authorize additional funding for services in the home. The National Committee strongly supports these efforts to strengthen the in-home component of the Older Americans Act.

Adult day care is another example of a service necessary to meet the growing need of aging members of our society, yet only about 25 percent of area agencies across the country subcontract for this service. Day care for the frail elderly serves to provide stimulation and socialization for seniors while it lets the caregiver attend to other family matters. Day care can also make the difference between the caregiver being forced to give up his or her job, and maintaining work outside the home. To encourage the development of more adult day care, the National

Committee proposes to make these services a priority under the Act for the next reauthorization period.

Respite. This nation is estimated to have between 2.5 and 3 million victims of Alzheimer's disease and related dementias. Many victims are in the early stages of the disease and are being cared for in the community by family members. These family caregivers of Alzheimer victims and other mentally and physicially frail older people desperately need respite services to keep going in the often very exhausting and exasperating job of caregiving. Adult day care and in-home services can provide invaluable respite from the daily caregiving responsibility. Senator Metzenbaum has introduced a proposal to create a home and community-based services block grant for victims of Alzheimer's disease and related dementias. The National Committee urges the Committee to consider such a proposal.

Volunteer Work Credits. As we age, we require more help from others -- help that is often difficult to accept. Americans traditionally have been brought up to be self-reliant and independent. Congressman Wyden has proposed an innovative volunteer exchange program which should make it easier for seniors to accept help from others. Older people would perform services for other seniors in exchange for work credits which, in turn, would get them free help in the future when they need it. These services would include such things as shoppping, home repair and homemaking. One survey found that twenty-five percent of seniors said they would be willing to volunteer on this basis. If these millions of older people volunteered just a few hours every week, it would translate into several billion dollars worth of help to seniors from other seniors. This idea should be implemented.

Advocacy: Legal Assistance

Older Americans often need legal assistance in asserting their rights to Social Security, Supplemental Security Income, Medicare and Medicaid benefits and to resolve housing or other consumer problems. Legal assistance is sometimes required to negotiate the bureaucracies and red tape encountered in trying to resolve benefit problems. Other times more serious legal problem arise. Many seniors do not know how to get help and frequently they cannot afford to hire a lawyer.

At a recent House Aging Committee hearing on legal services to the elderly, several case example were outlined. One such case was a 65-year-old woman with a broken hip who was neglected by her son. He left her immobile on a couch for three weeks, feeding her on average only once per day. Legal Services of Eastern Michigan obtained an injunction removing him from the house, returning her assets and arranging for nursing home care. Another example was a 73-year-old man who was being evicted from a senior citizens housing complex because the management considered him to be "too disruptive." His offense was changing the channel on the lobby televison too often. Eviction proceedings were successfully defeated.

One of the three priority service areas of Title III-B is to provide legal assistance for seniors. Although the Act states that "an adequate proportion" of III-B funds should go towards each of the three priority areas, nowhere in the Act or its implementing regulations is the "adequate proportion" language defined. A recent survey of legal assistance under the Older Americans Act, prepared by the American Bar Association's Commission on Legal Problems of the Elderly, found that funds for legal help under the Act have declined nearly 50 percent since 1980 after adjustment for inflation. In 1980 the average area agency on aging spent six percent of Title III-B funds on legal services. The National Committee recommends that the funding for legal assistance to the elderly be restored to the 1980 level by requiring six percent of Title III-B funding to be set aside for this purpose.

Advocacy: Nursing Home Ombudsman Program

The Older Americans Act also mandates advocacy for the institutionalized older person. Nursing home reform is one of the National Committee's highest priorities. Last year, we proposed a five-point plan for nursing home reform which called for improving inspections and strengthening enforcement of penalties for violations. We also called for a stronger Long-Term Care Ombudsman Program, the program charged with helping residents, families and friends of relative to resolve complaints and correct abuses.

To find out what kinds of problems our membership has encountered with nursing homes, we requested our members to write letters. In response, I received hundreds of letters from people across the country detailing experiences with nursing home abuse. A summary report of this information will be released soon from the the National Committee. One clear and uniform impression emerged from these letters, namely that basic human rights are being violated in too many nursing homes. For instance, respondents often complained of such things as being strapped in a chair for 8 and 10 hours a day, not being able to reach drinking water, of room temperature being too hot or too cold, of mail not being delivered in a timely manner, or mail having been opended by unauthorized individuals. Often nursing homes are understaffed and residents have to wait for long periods of time before there is a response to their call. A letter from a resident states: "I can't think of anything worse than having a "nature" call and no one coming to assist. Then when the "worst" happens, having to lie in my own waste for hours." Many of the problems described in these letters are the type of which the ombudsman can assist in solving.

Not only are ombudsmen needed in the nation's estimated 10 to 15 percent chronically substandard nursing homes, they are also serving an important role in solving problems between residents and the administration of well-run nursing homes. In one reputable facility in Maryland, the ombudsman was asked to intervene by a resident's daughter. Her mother, against her will, was to be moved to a closed section of the nursing home because her behavior was disruptive to other residents. The daughter was upset because she knew such a move would be detrimental to her mother's well-being. The ombudsman, by gaining access to the patient's records, discovered that the mother most likely was receiving too high a dosage of her behavior modification medicine. The ombudsman negotiated a few days' delay in the move during which time the resident was taken off the medicine. In the next couple of days the resident calmed down and a move was avoided.

The role of the ombudsman needs to be strengthened. Access to patient's records, for example, is not mandated in the Act. The Older Americans Act only sets up a framework and leaves to the states to set up the specifics guaranteeing access to facilities, access to patients and access to patients' records. Only a minority of states have passed ombudsman-enabling legislation since the program became part of Title III in 1975. This is a clear indication that action is necessary on the Federal level.

It is important to begin to look at expanding the Ombudsman Program to other settings where seniors are vulnerable. The ombudsman's responsibilities should be expanded to follow residents to the hospital. Also, as a demonstration project, ombudsman services should be provided in the home. Senator Glenn proposes both of these provisions in S. 959. It is essential, however, that no expansion be considered without additional funding.

States are required to designate one percent of Title III funds or $20,000, whichever is greater to Ombudsman services. Nationwide this amounts only to $12 or $13 million. Considering that 1.4 million people live in nursing homes and countless more in board and care facilities, the program is considerably underfunded, especially if the program is expanded, as we believe it should be. The National Committee supports Senator Glenn's proposal to place the Ombudsman Program under a new section D of Title III and to authorize $35 million for fiscal year 1988 and $40 million for fiscal year 1989.

S. 959 also calls for immunity for good-faith performance by the ombudsman. In addition, this bill would require access to facilities, to residents and to residents' records and more technical assistance from the Administration on Aging. These provisions would further strengthen the role of the ombudsman and the National Committee strongly supports such legislation.

Advocacy: Innovative Employment Services

Title V of the Older Americans Act, the Senior Community Service Employment Program, brings together both low income older Americans needing and wanting work and communities needing manpower for public services. It is a sensible solution which helps demonstrate the viability of the older worker. The program should be continued and should receive funding in line with authorized amounts.

But it should also be recognized that this program serves a very small percentage of the eligible population. In the last reauthorization, it was with this fact in mind that the Congress set aside funds for programs which emphasized training and placement of enrollees in private sector employment. In doing so, more Title V opportunities for older workers would become available.

These experimental training initiatives have proved promising enough to continue to expand this approach. But greater flexibility and demonstration of "innovation" would be welcome in this area. Because the current national non-profit agencies sponsoring Title V have built on a record of past performance, they have been limited by that same history in the development of truly innovative approaches to more effective placement of enrollees in the private sector.

In fact, with a few notable exceptions, there has been either great resistance to increased goals for placement of enrollees in private sector employment or unenthusiastic, and therefore uninspired, compliance. To address this we recommend that the Act be amended to provide for competitive bidding for administration of innovative training and placement projects.

By taking the step of opening up the innovative component of Title V, Congress can strengthen the training and placement component. It is our view that it is long past time that a few contractors enjoyed a protected monopoly of program design and responsibility.

Conclusion:

In summary, The National Committee wants to make the following recommendatations for the reauthorization of the Older Americans Act:

- clarify that the Older Americans Act is not covered by the OMB A-122 Circular;
- raise the Commissioner's position to Assistant Secretary;
- increase authorization levels by a minimum of five percent;
- authorize new funding for in-home services;
- make adult day care a priority service during the next reauthorization period;
- authorize a block grant for home and community services for victims of Alzheimer's disease and related disorders;
- adopt Congressman Wyden's bill regarding seniors earning volunteer credits;
- strengthen the Long-Term Care Ombudsman Program by creating a new section under Title III; increase funding considerably; mandate access to nursing homes, patients and patients' records; provide the ombudsman with immunity;
- expand the ombudsman mandate to hospitals and bring ombudsmen into the home health setting on a demonstration basis;
- strengthen legal assistance by requiring a 6 percent of Title III-B funding setaside;
- authorize competitive bidding for Senior Community Service Employment Program contractors for training and placement of enrolless in private sector Employment.

Conclusion

Finally we urge you to reaffirm the importance of the Older Americans Act by being as generous as possible when considering the reauthorization funding levels. Five percent may be realistic, but it hardly covers the demand for more services by an ever growing senior population. Let us not forget the objectives of the Older Americans Act - the very quality which makes the Act one of the most enduring symbols of this nation's basic concern for its aging members.

THANK YOU.

NATIONAL
ASSOCIATION
of
COUNTIES

440 First St. NW, Washington, DC 20001
202/393-6226

May 13, 1987

The Honorable Spark Matsunaga
U.S. Senator
Chairman, Subcommittee on Aging
404 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Matsunaga:

The National Association of Counties wishes to comment for the hearing record on the upcoming reauthorization of the Older Americans Act. Counties are deeply involved in aging programs. About one-third of the Area Agencies on Aging are county administered and many others allocate millions of county dollars to aging services.

We strongly support the Older Americans reauthorization. We feel that it has been an effective Act. It does not need major changes. Attached you will find our resolution on reauthorization adopted by the NACo Board of Directors on March 1987. From that resolution and from our discussions during markup of the House of Representatives bill, I have highlighted the following issues.

1. NACo supports a separate title and funding for in-home services for the frail elderly as is envisioned in the House bill, H.R. 1451. Addressing this issue, in light of the growing number of elderly, is critical. Federal resources are needed to assist local governments and families in allowing older Americans to remain in their homes.

2. NACo would oppose any provision giving states the ability to mandate that certain Area Agencies on Aging (AAA) require their program participants to share in the costs of some services. While we support the ability of AAA's to establish voluntary cost sharing, we oppose a state mandate or a means test for services. Unless it is implemented very carefully, cost sharing could change the nature of the Older Americans Act into a welfare program.

3. We continue to support local determination of priorities under the Older Americans Act. Area Agencies on Aging can best assess resources and determine local needs. Consequently, we oppose any earmarking of funds for any one service under Title III-B of this Act and would also oppose limiting the current ability to transfer funds.

We look forward to working with you and the Subcommittee as you prepare to mark up the reauthorization bill. We continue to support the Older Americans Act and the local flexibility it contains.

If you have any questions regarding our position, please call Tom Joseph of my staff.

Sincerely,

John Thomas
Executive Director

Enclosure

HUMAN SERVICES STEERING COMMITTEE
RESOLUTION ON
REAUTHORIZATION OF THE OLDER AMERICANS ACT

WHEREAS, the National Association of Counties strongly supports the intent of the federal Older Americans Act of 1965, as amended; and

WHEREAS, such act will come up before Congress for reauthorization in 1987; and

WHEREAS, counties administer one-third of all the nation's area agencies on aging and have been largely responsible for providing for the special needs and care of our older Americans; and

WHEREAS, counties and the local elected official deal with the problems of older individuals on a daily face to face basis;

THEREFORE BE IT RESOLVED, that NACo strongly endorses the reauthorization of the Older Americans Act and urges that the federal government appropriate adequate funds for the continued implementation of these programs nationwide; and

BE IT FURTHER RESOLVED, that NACo urges Congress to adopt the following specific recommendations in reference to the reauthorization of the Older Americans Act that:

- Local elected officials must be involved in the planning process for the Older Americans Act program;
- Counties be allowed first right of refusal in choosing whether or not they wish to be designated an Area Agency on Aging (AAA);

- Counties who decide not to be designated as an AAA have the right of approval of their area's service plan;
- The act and resultant regulations be simple, flexible and responsive to locally determined need, removing all bureaucratic requirements and giving localities the ability to target their resources;
- The maximum amount allowable as a transfer from Title III-C to Title III-B be expanded.
- Senior Employment, including age and income eligibility criteria, and Senior Volunteer Programs be transferred to the Administration on Aging;
- Area plans be required to address the issue of long-term care and identify a strategy for systems development in this area;
- The Title IV Research and Training Program be maintained;
- The reauthorization be for three years and the yearly authorization funding levels be retained;
- The separate titles under the Older Americans Act be retained;
- Funding to states continue to be based upon capitation of individuals 60 years of age;

- The current flexibility for AAAs to initiate/administer community or family care systems be retained;
- The Section 306(a)(2) requirement regarding adequate proportion of funding for specialized categories of services be deleted, thus providing for greater local determination;
- Title IV-A of the Act be retained with additional language providing the Commissioner on Aging with greater discretion to determine the Administration on Aging's funding priorities;
- The language allowing states to retain an additional 3/4 of 1 percent of funds for administrative purposes be deleted;
- There be included a separate title for the development of an Ombudsman Program with separate funding authorized for this purpose;
- The position of Commissioner on Aging be upgraded to an Assistant Secretary on Aging or that the Commissioner on Aging be required to report directly to the Secretary of Health and Human Services;
- AAA's and states be eligible to receive funding directly under Title IV;

- Voluntary contributions/cost sharing be included in Title III-B;
- AAA's be permitted under Section 306(a)(4) to provide case management services without a waiver;
- The Act be retained as a non-means tested program;
- Targeting of services be left to local determination;
- All federal legislation relating to the provision of services or information to the elderly specify, where appropriate, the role of the Administration on Aging, State Units on Aging and AAA's;
- The Act be retained as a separate line-item budget for the Administration on Aging which is not transferable to other federal programs;
- States be allowed to perform the AAA function where appropriate;
- Current intrastate funding formula language be maintained;
- Current language addressing provision of services to low-income minority be maintained in the Act and specified through regulations; and
- The Act continue to retain the hold harmless clause.

Passed by the Human Services Steering Committee
March 15, 1987

NATIONAL PUBLIC LAW TRAINING CENTER

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AGING SUBCOM
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April 24, 1987

The Honorable Spark Matsunaga, Chairman
Subcommittee on Aging
Senate Committe on Labor and Human Resources
Hart Senate Office Building, Room 404
Washington, DC 20510

Attention: Lois Fu

Dear Senator Matsunaga:

The enclosed commentary deals with re-authorization of the Older Americans Act, and specifically with the provisions in the Act defining legal services to the elderly.

The ABA Commission on Legal Problems of the Elderly has submitted a "White Papar" to the Congressional Committees handling re-authorization of the Older American Act, which suggests various amendments to the Act as it relates to legal services.

One ABA Commission recommendation is that the use of nonlawyers be prohibited in legal services to the elderly. We think otherwise.

We would consider such prohibition a great mistake, as the enclosed commentary explains.

If the issue deserves further attention I would be pleased to make an oral presentation at the April 30th hearing. In any event, I hope the enclosed commentary will be included in the record of the hearing.

Sincerely yours,

William R. Fry

William R. Fry
President

MAINTAINING AND EXPANDING
THE USE OF NON-LAWYERS IN LEGAL SERVICES
TO THE ELDERLY
UNDER THE OLDER AMERICANS ACT

A Commentary

By

National Public Law Training Center
Washington, DC

April 20, 1987

With the Support and Assistance of

The National Paralegal Institute
San Francisco, CA

SUMMARY OF THIS COMMENTARY

The Older Americans Act (OAA) provides funding for Legal Services to the Elderly. It establishes legal services as a priority among other services in the OAA. It mandates that Area Agencies on Aging (local entities which are the delivery mechanisms for services) give legal services "some" funding. The Act defines legal services as including services of lawyers, paralegals, law students, and nonlawyers.

In a recent briefing paper the American Bar Association Commission on Legal Problems of the Elderly has proposed to amend the OAA so as to prohibit the funding of legal services to the elderly if it is delivered by nonlawyers. This proposal would result in defunding some existing programs, and in foreclosing a means of legal services delivery which is economical, efficient and increasingly favored as a way to extend legal help. It would handcuff the aging network by depriving it of flexibility to design legal services to fit local conditions.

This commentary by National Public Law Training Center opposes the ABA Commission proposition, for these reasons:

1. Nonlawyers provide an important means of delivering effective legal services, and of expanding the specialized and limited services supplied by lawyers;

2. The Administration on Aging has long supported the use of nonlawyers in delivering legal services to the elderly;

3. This support has been endorsed and encouraged by Congress for almost a decade;

4. Many state and local programs for the elderly have invested in nonlawyer projects to serve the elderly;

5. The use of nonlawyers to serve disadvantaged people is an expanding concept which is embraced by the federal government, the elderly network, scholars, and bar leaders in the United States, England and Canada.

This is not a position opposing a role for lawyers in the AoA network. For litigation and complex legal issues they are essential. But lawyers are scarce and expensive. Nonlawyers should continue to be one solution for legal needs of the elderly, as they are for many other groups in society.

I. INTRODUCTION

This commentary discusses the role of nonlawyers in providing legal services. It in no way derogates the importance of lawyers for some aspects of legal services. Some legal problems require the expert help of a lawyers, while others do not. By its own admissions neither the organized bar nor the Legal Services Corporation is able to serve more than a fraction of the of the poor who need legal help. In 1978 the Legal Services Corporation said it could only serve one out of seven poor people eligible to be served, and its funding since then has declined.

> "The question is not whether there are some tasks that require the skills of a lawyer, but whether there are others that can be effectively handled by non-lawyers, particularly if the alternative is no lawyer, and thus no assistance at all."
>
> (Alan B. Morrison, director of the Public Citizen Litigation Group, writing in the Washington Post.)

References to nonlawyers in this commentary should be understood to mean persons who are trained and experienced in handling specific areas of legal problems. Unlike paralegals, who are direct employees of lawyers, nonlawyers may be employed by social services agencies, community groups, or may operate independently. They may have working relations with lawyers for consultation, support and referral of complex cases but they do not work directly for lawyers. As some studies have reported, qualified nonlawyers often have as much or more competence in their area as lawyers who work in that area, and greater competence than general practice lawyers.

Perhaps the Administrative Conference of the United States analsysis of nonlawyer administrative agency representation sums it up best. Using surveys and interviews with Social Security Administration, Internal Revenue Services, and Immigration and Naturalization Service - three agencies with massive exposure to both lawyer and nonlawyer representation of clients - the Administrative Conference finds that:

> "Investigation reveals that agency staff perceptions ... that nonlawyers as a class perform as competently as lawyers as a class at virtually all stages of administrative agency proceeding ... are supported by the agencies statistical data."
>
> .....[Based on the interviews and surveys] there is little discernible difference in effectiveness between lawyers and nonlawyers as groups. Rather, the differences lie in the relative intelligence and skills of the particular individual."

Nonlawyers are an effective way to deliver a range of needed services which will otherwise just not be provided, and their use should be encouraged in legal services to the elderly.

Since 1974 the Administration on Aging has supported programs for trained nonlawyers, often older people themselves, to give counseling, advice and representation to older people with legal and law-related problems.

The limitation against nonlawyers recommended by the ABA Commission would cancel many nonlawyer legal services projects now in existence, and restrict utilization of nonlawyers for the elderly in ways which AoA has been supporting for over twelve years. It would deprive older persons, and the State and Area Agencies on Aging who serve them, of an economical way of supplying important legal help.

The proposed ABA Commission amendment would require that all funds for legal services to the elderly go to projects of the Legal Services Corporation, or to similar lawyer-controlled groups, or to private attorneys. AoA and the aging network could no longer follow the national trend toward increased use of nonlawyers, especially in the administrative law areas in which so many elderly people are involved.

This commentary by National Public Law Training Center is submitted to the Senate Subcommittee on Aging, Labor and Human Resources Committee, United States Senate, at their request, and it summarizes why the Older Americans Act should not be revised in respect to use of nonlawyers; how nonlawyers are currently being accepted throughout our legal system; and why their continued use in the aging network should be supported by Congress.

The National Public Law Training Center is a Washington, DC, nonprofit agency which trains nonlawyers and paralegals in law and skills needed to serve, the elderly, poor, handicapped, developmentally disabled, and other disadvantged groups.

II. The ADMINISTRATION ON AGING's SUPPORT OF NONLAWYERS FOR THE ELDERLY

In 1974 AoA funded a pilot project to support the use of nonlawyers. This project developed training materials including films and video tapes to teach the skills and substantive knowledge nonlawyers needed to represent clients in disability administrative hearings.

From 1975 to 1978 AoA funded the California Department of Aging to promote a state-wide network of legal services projects for the elderly. Over half of the projects supported used nonlawyers, and substantial nonlawyer training was given to over 200 people, with emphasis on public benefit representation.

In 1976 AoA funded the National Paralegal Institute for a national training effort which gave training to nonlawyers in 35 states and established networks of trained nonlawyers some of which are still in place.

In 1978 the provision of the OAA dealing with legal services was amended to specifically encourage the use of nonlawyers for delivery of legal help to older people. The provision, still the law, defines "legal assistance" as:

> " ... legal advice and representation by an attorney including, **to the extent feasible**, counseling or other appropriate assistance by a paralegal or law student under the supervision of an attorney and including counseling or representation by a nonlawyer where permitted by law to older individuals with economic or social needs." (emphasis provided)

The amendments in 1978 indicated Congressional approval of what AoA had already been supporting through national and state training and demonstration grants - the use of nonlawyers as a component of legal services. The language "to the extent feasible" preceding the mention of paralegals, law students and nonlawyers indicates a statutory preference for those providers of service.

This preference reflects a commitment to an integrated, multi-service delivery system in which there are different levels of expertise and of cost. In addition, nonlawyers provide a link between social services agencies which are in direct contact with the elderly, and the lawyer services which come mostly from the separate Legal Services system.

In 1979, AoA created five Bi-Regional Centers to support the extension of legal services, including training for nonlawyers as well as lawyers and paralegals. Since legal services was made a statutory priority under the OAA many states and communities have established nonlawyer systems for the elderly. Often they are linked with Legal Services Corporation projects or with private attorneys for support; sometimes they utilize a staff attorney; sometimes no such resources are available.

State and Area Agencies on Aging face diverse problems. Some must administer services in rural areas where no lawyers are to be found; others are centered in retirement communities where older lawyers abound. Some have constituencies with problems of food and shelter, while for others the dominant problems are health, or transportation. Legal problems differ from place to place; in one area it may be race-related problems, in another zoning, in another age discrimination. The format of services must reflect all these differences. For many state and area agencies the use of nonlawyers is the only feasible or economic system. And for all Area Agencies one universal legal problem is eligibility for public benefits such as Supplemental Security Income - matters which nonlawyers are specifically authorized by law to handle.

Nonlawyer systems are now in place state-wide or in substantial areas in Vermont, Virginia, West Virginia, Texas, California, Oregon and New Mexico, among others. In addition, many local communities utilize nonlawyers as the best, or in some cases the only, option available.

III. OVERVIEW OF THE USE OF NONLAWYERS IN PUBLIC LAW FOR THE POOR .

Over the last twenty years it has been the policy of federal and state agencies to rely on nonlawyers, whenever feasible, to deliver legal and law-related services including advice and representation to individuals in need of legal help (for example, immigrants and aliens, handicapped, veterans, Indians, and developmentally disabled).

A 1986 report and recommendation of the Administrative Conference of the United States (ACUS) addressed the use of nonlawyers in mass justice agencies - those federal agencies having a high volume of individual and family claims, applications or disputes.

The ACUS report traced the history of nonlawyers in representing individuals in matters involving administrative rights and remedies. It pointed out that some agencies had made explicit provisions for nonlawyers to give full representation to clients having matters before the agencies, including legal advice and hearing representation (e.g., Internal Revenue, Immigration and Naturalization, and the Patent Office). In these agencies, experiences with nonlawyer quality has been positive.

The Supreme Court of the United States has repeatedly endorsed the use of nonlawyers. In Sperry v. Florida ex rel Florida Bar (1963) the court found that, not withstanding the legal complexities of patent cases, nonlawyers could engage in patent law practice pursuant to federal authority, and State Bars could not stop them under Unauthorized Practice of Law rules.

IN Walters v. National Association of Radiation Survivors, (1985) the court declined to remove a $10 ceiling on lawyer's fees for representing veteran claimants, since the court found that nonlawyers were providing adequate service in such matters and their was no need to increase the involvement of lawyers.

In a 1969 case involving the right of nonlawyers to assist prison inmates with legal claim, Justice Douglas spoke broadly on the need to permit nonlawyers to perform what was traditionally thought of as lawyers' work, saying:

> "There are not enough lawyers to manage or supervise all these affairs [establishing the basis for claims and preparing the paper work to assert them] and much of the basic work requires no special legal talent."
> (Avery v. Johnson)

The ACUS report was based in part on interviews with administrative judges and agencies who observed and worked with nonlawyer advocates. The conclusions were that, where agencies permit nonlawyer advice and representation (such as in Social Security, Immigration and Tax matters) the nonlawyers provided services as competent as lawyers did, and since lawyers could not meet all the needs of the public, nonlawyers use should be expanded.

For as long as people in need have been helped by community-based agencies, nonlawyers in those agencies have assisted with legal and law-related problems. These include problems range across government benefits such as Social Security, Supplemental Security Income and Medicaid; spousal abuse; problems encountered in nursing homes; elder abuse and neglect; housing and financing issues; and a variety of other matters from disputes with landlords to consumer complaints to transportation needs.

Neither the private bar nor the projects of the Legal Services Corporation have been able to help with more than a fraction of the legal problems of the poor, and this is not likely to change. The use of nonlawyer delivery systems in conjunction with lawyers will continue to be an effective and prudent way to meet the demand for help.

Federal and state laws specifically authorize nonlawyers to counsel and represent people in dealing with eligibility for, or termination of an array of public benefit programs. Moreover, there is a trend away from using lawyers as administrative hearing officers - a trend which parallels the use of nonlawyers for legal assistance. The nonlawyer regulations of agencies such as Social Security and the Veterans Administration recognize that many disadvantaged people (1) cannot deal effectively with bureaucracies or with laws and regulations, (2) cannot advocate for themselves, and (3) cannot afford a lawyer or find a free lawyer who will help them.

In the public law sector, neighborhood legal services projects began utilizing paralegals and the Office of Economic Opportunity, Legal Services division (predecessor to the Legal Services Corporation) created a national center in 1972 to support paralegal training and employment by the projects.

Unlike paralegals in private law firms who are often assigned to an attorney-supervisor, many of these LSC paralegals have gained such expertise in administrative law that they serve as parallel providers with the lawyers, sometimes physically located in separate offices which they - the nonlawyers - administer. Concepts of lawyer supervision become moot when the only person in an office who knows SSI law is a nonlawyer.

Since 1968, many new initiatives for legal services to selected groups have relied mainly on nonlawyers to deliver the services. Programs for the handicapped, disabled, consumers, nursing home residents, abused spouses, immigrants, minorities, unemployed, veterans, and others resulted in cadres of trained nonlawyers providing assistance, often with the backup of a lawyer for those cases requiring a lawyer's services.

Nonlawyers are almost always trained in the specialties which they handle, ranging from Supplemental Security Income eligibility to consumer rights to rights of the handicapped. Experienced nonlawyers do a great deal more than mere community education or information and referral. As permitted by law they advise, counsel, negotiate for and represent clients. Experienced nonlawyers are often more knowledgeable about their specialty than the average lawyer, and many of them have established impressive records of victories at administrative hearings.

IV. THE SERVICES NONLAWYERS PERFORM

The ABA Commission recommendation tends to trivialize the work of nonlawyers and emphasizes that, in any event, states have rules against unauthorized practice. It fails to mention that large areas of legal practice are permitted to nonlawyers by state and federal laws.

Moreover, the Commission does not admit that there is virtually no accepted definition of the "practice of law" and that nonlawyers have worked for years without challenge in such areas as nursing home ombudsman, consumer assistance, employment rights, and rights to health care. The ACUS report refers to the ongoing quandry over defining "complex" matters requiring a lawyers as a "sometimes metaphysical debate." In any event, it is clear that:

1. There are enormous areas of legal needs among the elderly which nonlawyers are permitted by law to service, and which they are perfectly competent, as a group, to perform;

2. There is a marked trend toward expanding these areas for nonlawyers for reasons of efficiency and cost-savings;

3. Congressional action to prohibit the use of nonlawyers for the elderly would set the Administration on Agency apart as one of the few federal human services agencies not supporting expanded use of nonlawyers.

To quote Morrison from the Washington Post:

> "As one who has represented a number of non-lawyers in challenges to the rules against unauthorized practice of law, it appears to me that there are many tasks in areas of great concern to the poor, such as divorce and bankruptcy, which could easily and properly be handled by persons who are not full-fledged lawyers - and at a fraction of the cost. But the bar sees this as an incursion on its turf, and the twin terrors of protectionisms and paternalism immediately emerge as a reaction to any suggestion that lay assistance might be a means of solving one part of the problem of delivery of legal services to the poor."

The ABA Commission recommendations does not, it appears, reflect a position of the ABA itself on this matter. In 1986 the ABA Commission on Professionalism, chaired by former ABA President Justin Stanley, stated in a report:

> "No doubt, many wills and real estate closings require the services of a lawyer. However, it can no longer be claimed that lawyers have the exclusive possession of the esoteric knowledge required and are therefore the only ones able to advise clients on any matter concerning the law. Inroads on lawyer exclusivity have been made and will continue to be made. "

By way of example of the variety of work nonlawyers now do, several networks of nonlawyer-type legal services systems will be mentioned.

A. Protection and Advocacy.

Funded through the Vocational Rehabilitation Act is a national network of Protection and Advocacy agencies serving the developmentally disabled. Every state has a P&A agency, usually with branch offices throughout the state. The almost universal staffing of these agencies is that they are headed by a layperson and staffed by trained nonlawyers. Most P&As have a lawyer either on staff or available by contract to handle cases requiring a lawyer's skills. The nonlawyers handle, among other things:

1. Cases arising under section 94-142 of the Education Act involving legal rights of the handicapped to special education. Services include advice, negotiation, and hearing representation.

2. Social Security and Supplemental Security Income benefit eligibility and termination of benefits. Services include advising on eligibility standards, helping prepare an application, advising on legal rights after denial of benefits, and preparing and presenting a case at an administrative appeals.

B. Client Assistance Projects

Funded by the Rehabilitation Services Administration, every state is given federal support to operate a Client Assistance Project to help the handicapped with legal rights arising from employment problems. The staff serve as legal advisers, representatives and advocates for the handicapped. Their task is to insure that a range of employment-related benefits such as special education and training, prosthetic devices, and counseling are received, and that cases of employment discrimination or problems of physical access are resolved. Most of these topics are grounded in statutes and regulations. CAP staff give advice, counseling and representation at administrative hearings.

C. Mental Health Advocacy.

By statute enacted in 1986, every state Protection and Advocacy agency will receive funding for mental health advocacy. The new initiative will be staffed primarily by nonlawyer's with lawyer backup. The goal is to deal with the legal rights of patients in mental health institutions including rights to treatment, protection from abuse and neglect, and rights to privacy.

D. Immigration and Naturalization Services.

INS has supported networks of non-profit agencies around the country, staffed by nonlawyers who provide advice and representation to immigrants and aliens. Nonlawyers working in approved agencies give advice, help assemble documents and prepare applications, and provide personal representation at hearings.

In response to recent amendments to immigration laws, INS will be activating thousands of nonlawyers, employed in community-based agencies, to assist and represent aliens in the legal technicalities of the new laws and in pursuing their rights.

E. Nonlawyers as Hearing Offices

The Social Security Administration, the largest and most experienced adjudicative agency in the country, is installing a new level of administrative hearings for disability cases. SSA has decided that the 450 new hearing officers for this process will be nonlawyers - a departure from their previous practice of using only lawyers as administrative law judges. The functions and responsibilities of the new judges will be virtually identical to existing administrative law judges. The SSA decision was based on economy, known performance of nonlawyers, and a wish to avoid undue legal complexities in case processing.

California and a number of other states are also using nonlawyers as hearing officers in such administrative areas as welfare and parole.

F. Nonlawyers as Representatives of the Government.

In administrative hearings the government often has a representative to present its side of the case. Traditionally these have been government lawyers, but for reasons similar to the use of nonlawyers as judges, this is changing. In California, nonlawyers now represent the government in hearings before OSHA (Occupational Safety and Health), the Department of Agriculture, and the state Welfare Department.

The foregoing summaries shows only a few of the areas in which nonlawyers, with no fanfare and little opposition from the bar, are taking over jobs which were once thought to require a lawyer.

It is as difficult to describe the work of nonlawyers as it is to describe what lawyers do. Both groups tend to specialize - nonlawyers even more so - and every specialty has its own functions.

Tax nonlawyers advise on complex laws and regulations and appear at hearings on issues of law and fact. A nursing home ombudsman must be familiar with patients' rights, laws on treatment and custody, rights of privacy, laws governing access to institution's records, and public benefits for health care. Immigration specialists advise on eligibility for citizenship, legal procedures to apply, risks of deportation, documentary evidence to prove residence, and also appear at hearings. Representatives of the disabled and handicapped may advise on legal rights under various federal and state laws giving special rights to the handicapped, participate in negotiations over alleged employer violations of laws, and appear in hearings on such matters as special education for handicapped children.

V. NONLAWYERS EXPANDING ROLES IN OTHER AREAS OF LAW

The foregoing has mainly discussed nonlawyers in "public" law, involving administrative rights and proceedings, or special services funded by the government. In the private law sector, where legal relations between individuals or companies is the focus, nonlawyers have always played a role, and it is growing.

For the better part of this century citizens have had counseling and representation on legal matters from accountants, tax consultants, realtors, bankers and similar professionals whose work is partially legal in nature. Features of the work of these groups would be the practice of law by most measurements, but they have the expertise and political power to withstand attack by lawyers. Until the 1960s, Bar Associations sometimes entered into "treaties" with such groups agreeing that they would not challenge them for practicing law. (Those agreements were subsequently withdrawn for fear of anti-trust violations, but the unspoken accommodations continue).

Over the past several decades, groups have been formed at the community level to assist people with special problems and needs, from consumers to abused spouses to immigrants, the unemployed, and those with learning disabilities. Self-help groups have also appeared for women business owners, opponents of zoning rules, and endless other topics of concern. In many instances, lay persons become advisors and representatives to others in the group - giving legal advice, helping draw documents and appearing as advocates.

Experience with nonlawyers and common sense has led most observers of the legal scene to conclude that many legal services could be delivered by trained nonlawyers. There are organizations now producing self-help law books on how to write a will, deal with a landlord, or obtain a divorce. Neighborhood based independent paralegals are establishing separate businesses to specialize in matters in which they are expert, such as SSI eligibility, or unemployment benefits, incorporation, or uncontested divorce.

In England there are over 750 Citizen Advisory Bureaus staffed by nonlawyers who give advice and representation in a wide variety of matters. They handle three million cases per year.

In Canada the independent paralegal concept has been accepted, and legislation is pending in Ontario to establish the right of nonlawyers to handle some kinds of cases including minor criminal matters and simple domestic and commercial transactions. Called the "Paralegals Agents Act" it will authorize independent nonlawyers (subject to education and discipline rules) to appear before certain courts and administrative bodies such as small claims court, Provincial Offense (criminal) Courts, landlord and tenant tribunals, immigration boards and coroners' inquests.

In summary, nonlawyers are being increasingly used and recognized as alternatives or supplements to lawyers not just for the poor, or in public law, but across the spectrum of legal needs of citizens.

VI. CONCLUSION

The use of nonlawyers for the elderly has been long mandated and well established. It is a concept of delivery which is receiving acceptance by scholars, by many federally supported projects, and in society at large in English-speaking nations. It would be an anachronism, and a serious blow to legal services to the elderly to have Congress force AoA to confine its delivery systems to only lawyers.

SELF-HELP
FOR THE
ELDERLY 安老自助處

840 PINE STREET, [illegible], (415) 982-8171

AGING SUBCOM
87 [illegible]

April 21, 1987

Ms. Lois Fu, Staff Director
Subcommittee on Aging
Committee on Labor & Human Resources
404 Hart
Senate Office Building
Washington D.C. 20510

Dear Ms. Fu:

On behalf of the San Francisco Coalition of Agencies Serving the Minority Elderly (CASME), I'm submitting a position paper on the reauthorization of the Older Americans Act for your consideration.

We understand the Senate Subcommittee on Aging will be holding hearings on this matter. We request that our recommendations be made part of the public testimony taken during the hearings in Washington, although we cannot be there in person to deliver them.

A list of the CASME Members is also attached to our statement. If you have any questions, please feel free to contact any one of us on the list.

May we receive a complete copy of the testmony after the hearings are closed? We'd appreciate any comments you or members of the subcommittee have onthis issue. We also like to be of further help to you in the future if you need more information on the minority elderly programs in San Frarcisco. If there is anything CASME can do to advocate for some of the positive changes to improve services to the minority seniors, please let us know. Please keep us informed of the status of the reauthorization.

Many thanks.

Sincerely,

Anni Chung

Anni Chung
Executive Director

encl:

HELPING SENIORS SINCE 1966

POSITION PAPER ON RECOMMENDATIONS TO CONGRESSIONAL SUBCOMMITTEES ON AGING 'S HEARINGS ON REAUTHORIZATION OF THE OLDER AMERICANS ACT:

The San Francisco Coalition of Agencies Serving Minority Elderly *(CASME) aims to improve the economic, social and physical well-being of the older minorities by addressing issues that directly affect our quality of life.In particular, it seeks improved living conditions, better job opportunities, greater participation in public/private programs and agencies, and increased awareness of the status of minority elderly and of our many contributions to the society.

CASME would like to submit its recommendations to both the U.S. Senate and the House's Subcommittees on Aging on the Reauthorization of the Older Americans Act.

I.) CASME is alarmed that Minority participation in Title III programs under this Act has steadily decreased throughout the 80's. The Federal Intent of the Older Americans Act, as amended in 1984, is very specific in its language as to whom the services under this Act should be targeted for : " ......**provide assurances that preference will be given to providing services to older individuals with the greatest economic or social needs, *with particular attention to low-income minority individuals,* and include methods of carrying out the preference in the State Plan."**

The status and resources of many minority elderly reflect social and economic discrimination experienced earlier in life. Many, especially those who migrated to the U.S., face cultural and language differences as well. Nearly 4% of older minority Californians have zero or limited English speaking ability. Consequently, minority elderly have increased risks of poor education, substandard housing, poverty, malnutrition and generally poor health.

CASME strongly recommends that the intent of the Older Americans Act be reinstated with emphasis on targeting resources to the low-income minority elderly. Since the State and Area Agencies on Aging are responsible for distribution of the resources, language shoud be added to both State and Area Plans to provide special targeting of OAA funds to minority elderly and special populations. Each State Plan should include a strong Mission Statement on outreach and making services accessible and culturally responsive to minority seniors. It is necessary for language to include bilingual, bicultural programs as specific methods of outreach and services to the minorities. Intrastate Funding Formula (IFF) of each State should reflect targeting older minorities for services in proportion to their needs.

2) CASME recommends strong language be adopted to strengthen and support the advocacy role of Community Based Organizations (CBOs) in Section 305 & 306 of the Older Americans Act. Advocacy is essential and crucial to ensure and increase the participation of more minority elderly in OAA-funded programs.

ADVOCACY, as defined by CASME, is meeting the needs of minority elderly through effective community organization, education, outreach, empowerment of the seniors and seniors-serving network via full awareness and utilization of existing and new resources. Advocacy is also doing what is necessary to eliminate barriers to guarantee services for seniors to be available, accessible and affordable. To meet the social and economic needs of minority elderly, an advocacy role by cultural-unique CBOs is definitely an asset. Without it, participation by minorities is greatly hindered.

We recommend the OAA's intent to fulfill the advocacy role should be spelled out in clear, concise language which will not leave room for misinterpretation and avoidance by the States and Area Agencies, who often are not pursuing this intent vigorously.

3.) There is a great need for Technical Assistance and Training funds for minority elderly serving agencies. As it stands now, community agencies cannot apply for training funds under OAA. In cities with large minority populations, training and technical assistance should be made available to those minority community-based organizations(CBOs) and their national affliates which can play a more appropriate role in providing cultural sensitivity training programs to other aging providers, both public and private. Without additional resources, CBOs cannot take on additional burdens. **CASME recommends that Title IV Training funds be accessible to local and national minority groups and community based service providers.** Emerging minority elderly groups also need technical assistance in outreach and advocacy, to overcome barriers and to compete for grants.

4) CASME recommends special appropriations under OAA Reauthorization directly targeted to minority community-based organizations to develop special programs in advocacy, outreach, nutrition and supportive services to the minority elderly. These special demonstration projects will also provide future data on the causes of the lack of or reduction of minority participation in OAA -funded programs.

5) Cultural and language barriers, along with physical isolation and lower income, often make using health care services difficult to the minority elderly. Minorities also have a shorter life expectancy compared to the white population. Therefore, **CASME strongly recommends that the eligibility for OAA-funded services to remain at age 60.** CASME **opposes to *any* change of this threshold.**

6) In light of the increase of health and safety hazards for the frail elderly following the implementation of the new payment method by Diagnostic Related Groups (DRG) for hospitalization care , **CASME recommends the expansion of Title III Supportive Services to cover for 24-hour In-Home Supportive Services including services for seniors with Alzheimer's Disease.**

7) In 1980, over 2.5 million persons, or 10%, of the population 60 or over in U.S. were non-white. In California , the minority elderly population constituted 679,139 or 17 % of its 60+ population. In San Francisco, Asians, Black and Hispanic seniors make up almost 32%, or 43,347 of the 60+ polulation, which in 1980, was 20% of the city population , or 137,681 in total. San Francisco, thus, by sheer statistics, leads the nation in minority elderly and is a pioneer in providing a wide range of services to them that are unique and culturally sensitive.

San Francisco , despite its success in serving minority elderly, is burdened with a high concentration of economically and socially disadvantaged seniors and families attracted to the city by its receptive social climate and its cultural diversity. Federal programs are not providing adequate help to this group of underserved seniors, as evidenced by the ever-increasing number of homeless, poor, minority elderly who roam the streets of San Francisco every night.

CASME recommends Federal initiatives under the Older Americans Act be aimed at cities with exceptional high concentration of minority seniors, such as San Francisco, to maximize resources for this group of needy seniors by close linkage of government programs with local community-based organizations who have proven their effectiveness in serving their seniors. " Self-determination " has been the underlying principle for many successful anti-proverty programs which began their mission in the 1960's , survived the 70's and are thriving community agencies in the 80's. If the intent of the OAA is to provide services to the minority seniors, the best approach will be to work closely with each minority community's focal point, usually a CBO with bilingual, bicultural programs, to guarantee maximum participation by low-income, minority seniors.

8) **CASME supports a minimum of 5% increase for the new appropriation for the Older Americans Act.** However, recognizing the alarming reduction of minority participation in its programs in light of the demographic changes of our minority elderly population , **we strongly recommend new monies be earmarked specifically to increase minority participation in ALL OAA-funded programs** . Each State and Area Agency on Aging should be required to conduct annual Needs Assessment for its low-income minority senior population. Allocation of federal funds should be closely tied to whether that area meets the needs in proportion to its minority elderly population. The new appropriation should have "teeth" in its language so that each State and each Area Agency fulfills the federal intent of targeting resources to the minority elderly population.

9) Even with the proposed 5% increase, CASME is fully aware that there will never be adequate funding to meet all the needs of minority elders. **We therefore urge for congressional leadership to identify NEW sources of funding to meet such needs.** A special appropriation can be set aside as "incentive funds" for States , Area Agencies or minority CBOs who can secure additional funding from the private sector to implement more services for the minority seniors.

Despite United States's acclamation as a World Leader, it is not known for its respect and care of its elderly. Older people, particularly those from the third world countries , often suffer " cultural shock " by the way seniors are treated here. It is a fact that the U.S. extols youth and disregards seniors.

CASME strongly urges our Legislators to seize this opportunity to restore the love, respect and comfort for its older Americans, with special emphasis for the minority elderly. With foresight, determination and commitment, the reauthorization of the Older Americans Act in 1987 can become the guiding light for senior services and programs that are culturally unique to maximize participation by the minority elders.

In closing, CASME puts forth the challenge to both House and Senate Subcommittees on Aging of recommending amendments to the Older Americans Act that will ensure minority access to services and to enhance the status of minority elderly in the U.S. CASME believes that, together, minority, and non-minority elderly can enrich each other's lives and achieve the goal of a secure, fulfilling life for all older Americans.

Prepared by Anni Chung
April 21, 1987

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NEW YORK STATE OFFICE FOR THE AGING
Nelson A. Rockefeller Empire State Plaza, Albany, NY 12223-0001
MARIO M. CUOMO
Governor
EUGENE S. CALLENDER
Director

'87 MAY 11 AM 11:14

May 5, 1987

Honorable Spark Matsunaga
U.S. Senate
SH-109 Hart Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Matsunaga:

Thank you for the opportunity to provide written testimony for inclusion in the hearing record of the Subcommittee on Aging Older Americans Act hearing.

As you will note in the attached comments, the recommendations were prepared jointly by the New York State Office for the Aging and New York State Association of Area Agencies on Aging.

If you have any questions or need additional information, do not hesitate to contact me. Thank you for your efforts to reauthorize the Older Americans Act.

Sincerely,

Eugene S. Callender

Eugene S. Callender

Att.

1-800-342-9871 Senior Citizens' Hot Line
Call toll-free for information about local programs and services
An Equal Opportunity Employer

Recommendations for the 1987 Reauthorization
# of the Older Americans Act
# of 1965, as Amended

Submitted jointly by the

New York State Office for the Aging

&

New York State Association of Area Agencies on Aging

Portions of this paper were originally prepared by NASUA/N4A; inclusion here signifies the support of New York State's Aging Network.

March 1987

1. REAUTHORIZATION PERIOD

It is recommended that appropriations under the Older Americans Act be reauthorized for a period of three years, or through September 30, 1990. Concerning the time period for State plans -- it is recommended that the current language in Section 307(a) be retained: . . .each State, in order to be eligible for grants from its allotment under this Title for any fiscal year, shall submit to the Commissioner a State plan for a two, three, or four year period.

2. TITLE I

(new) Section 101(11) Support to family members and others providing voluntary care to those older persons needing long term care services.

3. TITLE II -- PLACEMENT OF AOA

An Assistant Secretary for Aging should be established within the Department of Health and Human Services (DHHS) with responsibility for representing the interests of all older Americans within DHHS and with other federal departments and agencies, and for administering the Older Americans Act program.

If the Act is not changed to provide for an Assistant Secretary for Aging the following is proposed for the Office of the Commissioner on Aging.

Section 201(a) ...there shall be a direct reporting relationship between the Commissioner and the (Office of the) *Secretary. In the performance of the functions of the Administration, the Commissioner shall be directly responsible to the (Office of the) Secretary.

*The use of parenthesis throughout indicates material to be deleted. The use of underline indicates new material to be added.

4. AUTHORIZATION OF APPROPRIATIONS

The figures proposed below represent a 10% increase in existing authorized funding levels for Title III, for each of the three fiscal years. Justification is based on the fact that OAA appropriations have barely kept pace with inflation over the past seven (7) years and have not come close to keeping up with the population explosion among the elderly over the last two (2) decades. From 1970 to 1980 real national growth in the older population was as follows:

65 plus increased 27.8%

75 plus increased 32.3%

85 plus increased 59%

Projected growth from 1980-1990 is as follows:

65 plus - 24.1%

75 plus - 37%

85 plus - 47.9%

Section 303(a) There are authorized to be appropriated $397,650,000 for fiscal year 1988 $437,415,000 for fiscal year 1989, and $481,156,500 for fiscal year 1990 for purposes of making grants under Part B of this Title (relating to supportive services and senior centers).

(b)(1) There are authorized to be appropriated $434,500,000 for fiscal year 1988, $477,950,000 for fiscal year 1989 and $525,745,000 for fiscal year 1990 for the purpose of making grants under subpart 1 of part C of this Title (relating to congregate nutrition services).

(2) There are authorized to be appropriated $83,160,000 for fiscal year 1988, $91,476,000 for fiscal year 1989, and $100,623,600 for fiscal year 1990 for the purpose of making grants under subpart 2 of part C of this Title (relating to home delivered nutrition services).

SINGLE ORGANIZATIONAL UNIT

Section 305(c)(2) any office or agency of a unit of general purpose local government, which is a single organizational unit designated for the purpose of serving as an area agency by the chief elected official of such unit;

Section 305(c)(3) any office or agency which is a single organizational unit designated by the appropriate chief elected officials of any combination of units of general purpose local government to act on behalf of such combination for such purpose.

Section 305 (c)(4) any public or nonprofit private agency in a planning and service area, or single organizational unit within it, which is under the supervision or direction for this purpose of the designated State agency and which can engage in the planning or provision of a broad range of supportive services, or nutrition services within such planning and service area.

DESIGNATION

Section 305(c) an area agency on aging designated under subsection (a) shall be-[subsections 1 through 5] . . .and shall provide assurance, determined adequate by the State agency through an on-site assessment, that the area agency will have the ability to develop an area plan . . .

COST SHARING

(new) Section

The Commissioner shall select a minimum of two but not more than eight State Units on Aging to participate in a demonstration project on cost sharing. The demonstration projects must be for a minimum of 12 months and not longer than 24 months. Under the demonstrations, cost sharing shall not be applied to services including but not limited to information and referral, outreach, advocacy and ombudsman. Included in each demonstration shall be an evaluation with a report submitted to the Commissioner on or before September 1, 1989. A summary of the evaluations shall be disseminated to each State Unit on Aging and Area Agency on Aging not later than January 1, 1990.

8. TARGETING TO FRAIL ELDERLY

Section 306(a)(6)(I) conduct efforts to facilitate the coordination of community-based, long term care services designed to retain individuals in their homes, thereby deferring unnecessary or inappropriate, costly institutionalization, and designed to emphasize the development of client centered case management systems through the utilization of functional assessment to determine need for services.

9. ADVOCACY

Section 305(a)(1)(D) serve as an effective and visible advocate representing the interests of older Americans (for the elderly) by reviewing and commenting upon all State and Federal plans, budgets, and policies which affect the elderly . . .

Section 306(a)(6)(A) conduct periodic evaluations (of) and public hearings on activities carried out under the area plan.

Section 306(a)(6)(D) serve as the advocate and focal point for the elderly within the community by monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and (community) actions which affect the elderly regardless of any prohibitions of OMB Circular A-122.

Section 307(a)(8) provide that the State agency will conduct periodic evaluations (of) and public hearings on activities and projects carried out under the State plan.

11. COMMODITIES

The authorization of appropriations for the USDA Commodity Distribution program is increased by 10% over the next three years.

Section 311(4) . . . level of assistance of not less than 59.60 cents per meal during fiscal years 1988 and 1989, and 62.60 cents for fiscal year 1990.

Section 311(c)(1)(A) . . .there are authorized to be appropriated $150,920,000 for fiscal year 1988, $166,012,000 for fiscal year 1989 and $182,613,200 for fiscal year 1990 to carry out . . .

12. OMBUDSMAN PROGRAM

TITLE III Part D (new title, formerly Section 307(a)(12))

(1) Provide assurances that the State agency will --

(A) establish and operate, either directly or by contract or other arrangement with any public agency or other appropriate private nonprofit organization other than an agency or organization which is responsible for licensing or certifying long-term care services in the State or which is an association (or an affiliate of such an association) of long-term care facilities (including any other residential facility for older individuals), a long-term care ombudsman program which provides an individual who will, on a full-time basis--

(i) investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities relating to administrative action which may adversely affect the health, safety, welfare, and rights of such residents;

(ii) monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities in that State;

(iii) provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities;

(iv) provide for training staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program; and

(v) carry out such other activities as the Commissioner deems appropriate;

(B) establish procedures for appropriate access by the ombudsman to long-term care facilities and patients' records, including procedures to protect the confidentiality of such records and ensure that the identity of any complainant or resident will not be disclosed without the written consent of such complainant or resident, or upon court order;

(C) establish a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities for the purpose of identifying and resolving significant problems, with provision for submission of such data to the agency of the State responsible for licensing or certifying long-term care facilities in the State and to the Commissioner on a regular basis;

(D) establish procedures to assure that any files maintained by the ombudsman program shall be disclosed only at the discretion of the ombudsman having authority over the disposition of such files, except that the identity of any complainant or resident of a long-term care facility shall not be disclosed by such ombudsman unless--

(i) such complainant or resident, or his legal representative, consents in writing to such disclosure; or

(ii) such disclosure is required by court order; and

(E) in planning and operating the ombudsman program, consider the views of area agencies on aging, older individuals, and provider agencies;

(F) ombudsmen shall be granted limited immunity from civil suits for good faith performance of their duties;

(G) ombudsmen shall have access to patients in hospitals who have been transferred to hospitals from nursing homes;

(H) the ombudsman program shall serve as an advocate for the elderly regardless of any prohibitions of OMB Circular A-122.

(a) there are authorized to be appropriated to carry out this Title $40,000,000 for fiscal year 1988, $44,000,000 for fiscal year 1989 and $48,400,000 for fiscal year 1990.

(b) amounts appropriated under this section for any fiscal year shall remain available for obligations until expended.

OMBUDSMAN PROGRAM cont'd

Section 304 (d)(1)(B)

(new) (B) in any year in which the State does not receive under Title III-d sufficient funds to conduct an effective ombudsman program under such Title, the rest remains unchanged

13. LIABILITY

no individual member of the governing body or advisory council of an Area Agency on Aging, or volunteer employee of an Area Agency on Aging shall, by reason of his performance on behalf of the agency of any duty, function, or activity required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision of a State) if he believed he was a member or employee, and with respect to such performance, acted without gross negligence or malice toward any person affected by it.

14. TITLE IV

Section 413

(new) Training Programs for Personnel in the Field of Aging

The Commissioner shall make grants to State agencies referred to in section 304,

(1) to coordinate the training efforts of all programs serving the elderly at the Federal, State, and local levels recognizing the continual growth of the elderly population;

(2) to assist in paying the costs, in whole or part, short-term and in service training courses, workshops, institutes and other activities designed to improve the capabilities of participants to provide services to older persons and to administer programs related to the field of aging;

(3) to assist in paying the costs, in whole or part, of post-secondary education courses of training or study related to the purposes of this Act, including the payment of stipends to students enrolled in such courses;

(4) for establishing and maintaining fellowships to train persons to be supervisors or trainers of persons employed or preparing for employment in fields related to the purposes of this Act;

(5) for seminars, conferences, symposiums, and workshops in the field of aging, including the conduct of conferences and other meetings for the purposes of facilitating exchange of information and stimulating new approaches with respect to activities related to the purposes of this Act;

(6) to assess future national personnel needs, including the need for training of advocates, with respect to the elderly with special emphasis on the needs of elderly minority group individuals and the need for the training of minority group individuals to meet such needs;

(7) to assist in paying the costs, in whole or part, of special courses of training designed to meet the needs of service providers in rural areas;

(8) for the improvement of programs for preparing personnel for careers in the field of aging, including design, development, and evaluation of exemplary training programs, introduction of high quality and more effective curricula and curriculum materials

Section 420

(new) (6) provide technical assistance to State Units on Aging and Area Agencies on Aging in carrying out their responsibilities.

Section 422(b)

(new) (9) Address the causes and remedies associated with neglect abuse and exploitation of the elderly.

(new) (10) Address the causes and remedies associated with decreasing participation rate in aging services of minority elderly.

(new) (11) Promote the availability of affordable and quality long-term care services.

Section 431 (a) There are authorized to be appropriated to carry out the provision of this Title $34,540,000 for FY 1988, $37,994,000 for FY 1989 and $41,793,400 for FY 1990.

TITLE V

Section 502(O)

(3) Of the amount for any project to be paid by the Secretary under this subsection, not more than (A) 15.0 percent for fiscal year 1988, fiscal year 1989 and fiscal year 1990.

(4) For the purpose of this subsection "eligible individuals" means any individual who is 55 years of age or older and who has an income equal to or less than the intermediate level retired couples budget as determined annually by the Bureau of Labor Statistics;

(a) or has an income greater than the intermediate level retired couples budget as determined annually by the Bureau of Labor Statistics, but equal to or less than 150 percent of the poverty level, provided that no more than 25% of funds appropriated under this Title shall be used to serve this population.

Section 508 (a) There is authorized to be appropriated to carry out this Title

(1) $405,130,000 for FY 1988, $445,643,000 for FY 1989, and $490,207,300 for FY 1990

16. TITLE VI

The position on Grants for Indian Tribes in the reauthorization is to continue to support direct funding to Indian Tribes, and to call for an appropriation which is at a level adequate to serve the eligible constituency.

Title VI recipients will not be precluded from receiving Title III services.

8. ADMINISTRATION -- AREA AGENCY ON AGING POSITION ONLY

Area Agencies on Aging feel that current statutory limit of 8.5% for administration is not sufficient. Therefore Area Agencies are seeking to increase the amount allowed for administration from 8.5% to 11%.

COMMUNITY BASED LONG-TERM CARE

A major commitment of funds is needed to develop and expand community based long-term care services for the elderly. Both Medicare cutbacks and diagnostic-related groups have had a drastic impact on the health care needs of older people. The long-term care system, which was not adequate to begin with, has been totally drained. To accommodate the current and growing need, a substantial commitment of federal funds is needed.

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Statement by

ALBERT D. BUFORD, III
Executive Director
Center for the Public Interest
Los Angeles, California

Before The

SENATE LABOR AND HUMAN RESOURCES COMMITTEE
Subcommittee on Aging

May 6, 1987

An affiliate of CPI Texas and Washington, D.C.

STATEMENT OF ALBERT D. BUFORD, III, Executive Director, Center for the Public Interest, Los Angeles, California.

MR. BUFORD: I would like to begin by expressing my appreciation to this Committee and its staff for inviting me to share with you my concerns at this time of reauthorization. Because you will hear from many, I will narrow my remarks and quickly become specific. All of my concerns expressed here relate to the definition of "legal assistance" within the Older Americans Act. Specifically, I am concerned about perpetuating, and indeed encouraging and expanding, the legal assistance now performed by non-lawyers.

The perspective I bring is a personal one. In 1975 I left my position as a VISTA lawyer at the Legal Aid Society of Hawaii to assist in expanding the work of non-lawyer advocates. It is their story, their work, to which I would like to direct the Committee's attention. It is their work, supported by AoA, first at the National Paraglegal Insititute, then later, and now, at the Center for the Public Interest, which I have been about. For better than a decade however, their labors have been too little noticed.

Today, throughout the country there are hard-working, non-lawyer advocates helping older persons with law-related problems. But for these advocates, many problems which older persons experience would go unaddressed. Many of these advocates are a part of the Older Americans Act network -- the aging network. It is these lay advocates which are the focus of my concern at this time of reauthorization.

In the mid-1970's the Administration on Aging funded a number of legal assistance model projects around the country, certain of which were designed to promote law-related advocacy by non-lawyers. For the most part, the focus of these programs was non-lawyers who, themselves, were participants in the Older Americans Act network, e.g., outreach workers and information and referral specialists. These projects tested the thesis that advocates who were operating in the aging network could spot problems which were law-related; the realization was that lawyers and paralegals, while serving a valuable function, would rarely stumble across the most serious cases. These same projects also made the point that without the work of these non-lawyer advocates, a permanent class of underserved, frail elderly individuals, experiencing public benefits problems, would grow.

NON-LAWYER ADVOCATES AND THE OLDER AMERICANS ACT

This era of AoA model projects also demonstrated that it was the advocate in the community who could engender the trust of the older client. And because of the huge numbers of clients needing law-related assistance, the point was also demonstrated that community advocates -- lay persons -- could be taught the law of public benefits and taught how to use the law to advocate in the public benefits arena. Example: The outreach worker who found an older person living on catsup soup could not only obtain food from a church food closet; the worker could also advocate for the waiver of an SSI overpayment, this when the client was innocent of wrongdoing and the evidence of hardship was spelled out.

As you know, federal law permits non-lawyers to represent clients with federal public benefits problems at all phases of their cases, short of judicial review. This includes representation at the administrative hearing, which is the most important step in public benefits advocacy since this is where the evidence (the record) is weighed.

In short, the Administration on Aging, with several years and several millions of dollars of model projects funding, and later with national advocacy assistance funding, has sought to insure that non-lawyers are at the heart of OAA "legal assistance". And on that point the Act, itself, is not silent. Rather, legal assistance is defined, in part, as:

> "...assistance by a paralegal or law student under the supervision of an attorney and including counseling or representation by a non-lawyer where permitted by law. . ."

Notwithstanding the above statutory definition of legal assistance, and the Administration on Aging's own funding of pilot programs utilizing non-lawyer public benefits advocates, there apparently is still some confusion over whether or not such non-lawyer advocates come within the Act's definition of "legal assistance".

The American Bar Association has, through its Commission on Legal Problems of the Elderly, circulated a White Paper to your Subcommittee containing recommendations for reauthorization. A number of the suggestions are excellent. However, Recommendation 7 confuses the role of non-lawyer, public benefits advocates with the role of paralegal advocates. As you likely know, paralegals are persons who work directly under the supervision of attorneys. Indeed their work product belongs to the attorney.

The Report states that, "The statutory exception for 'representation' by a non lawyer where allowed by state law, does not create a broad exception allowing paralegals, unsupervised by attorneys, to provide legal assistance within the meaning of the current statute." I agree. Again, a paralegal, by definition, is a person who is supervised by an attorney. The problem is that the Commission does not continue by explaining who can as non-lawyers advocate, without attorney supervision, i.e., non-lawyer public benefits advocates.

Please know that as an attorney I support the full continuum of legal advocacy, from lawyers engaged in impact litigation to non-lawyers engaged in public benefits advocacy. Each performs a critical service. For the most needy, particularly the frail elderly who suffer an inordinate degree of difficulty in dealing with public benefits problems, no person is more important than the volunteer or paid non-lawyer advocate operating within the Older Americans Act network -- the person who can cut through bureaucratic red tape, obtain eligibility where eligibilty has been denied and deal with post-eligibility crises.

Please know that I am committed to assisting your efforts to perpetuate both in spirit and in express statutory language, the vital work non-lawyer advocates perform in the OAA network. I support the work of both paralegals (operating under the direct supervision of attorneys) and other non-lawyers, including Community Service Advisors, who operate in the public benefits arena without the direct supervision of any attorney. I will be happy to point out specific programs, around the country, where non-lawyer advocates are providing legal assistance where, otherwise, no assistance would be available. I thus urge you to keep this non-lawyer advocacy at the heart of any OAA statutory definition of "legal assistance". I would also hope that any legislative history surrounding this year's reauthorization would reflect the belief that these non-lawyer advocates are, at least in part, exactly what the Act envisions as "legal assistance".

From the woods of West Virginia, to the urban areas of California, I have heard first hand the catsup soup cases -- older persons improperly, indeed illegally, denied sustenance, e.g., SSI. I know, first hand, how it is that non-lawyer advocates are the ones to spot these injustices. Over and over again I have seen these non-lawyer advocates tackle these problems and solve them. I urge this Committee to reflect, for a moment, on the nature of legal problems plaguing older persons. Then, I think, it should be clear: But for the non-lawyer advocate, most legal problems of older persons would never be solved. Indeed, most legal problems would never even be discovered.

At another time, Dr. Arthur Flemming on the subject of advocacy suggested that, "If the laws and regulations are not being applied ...they might just as well not have been passed or issued." (AoA Program Instruction 75-30). The non-lawyer is the best guarantee that legal problems are spotted as such; in the public benefits arena, I believe that non-lawyer advocacy programs also consititute the best stewardship of limited resources. I am confident that they fall within the Act's definition of "legal assistance", and I urge the Committee's support for a similar finding.

The State of Texas

SECRETARY OF STATE

I, JACK M. RAINS, Secretary of State of the State of Texas, DO HEREBY CERTIFY that the attached is a TRUE AND CORRECT copy of House Concurrent Resolution 25, passed by the 70th Legislature, Regular Session, 1987, as signed by the Governor on May 7, 1987, and filed in this office on May 7, 1987.

IN TESTIMONY WHEREOF, I have hereunto signed my name officially and caused to be impressed hereon the Seal of State at my office in the City of Austin, this

13th *day of* May *A. D. 19* 87

Jack M Rains

Secretary of State

H.C.R. No. 25

HOUSE CONCURRENT RESOLUTION

WHEREAS, Alzheimer's disease and related disorders afflict a substantial number of older Americans; and

WHEREAS, These disorders result in a lengthy degenerative process requiring a wide array of medical and social services throughout the course of the disease; and

WHEREAS, The type and length of care needed by Alzheimer's patients can be emotionally, physically, and financially devastating to the victims and their families; and

WHEREAS, Patients with Alzheimer's disease suffer progressive behavioral changes, cognitive decline, and increasing functional disabilities and display other characteristics that necessitate constant care and supervision; and

WHEREAS, To continue providing quality care for an Alzheimer's victim, it is necessary for family members to remove themselves periodically from the day-to-day hardships of caring for a loved one who may have become unmanageable; and

WHEREAS, Respite care provides the means for family members to take some much-needed time off, while knowing that the Alzheimer's patient is still receiving optimum care and attention; and

WHEREAS, As our country's elderly population increases, so, too, will the number of Alzheimer's patients, resulting in an increased demand for respite care and related programs; now, therefore, be it

H.C.R. No. 25

RESOLVED, That the 70th Legislature of the State of Texas hereby request the Congress of the United States to raise respite care for Alzheimer's disease victims and their families to a higher priority under the Older Americans Act programs; and, be it further

RESOLVED, That the Texas secretary of state forward official copies of this resolution to the president of the United States, to the speaker of the house of representatives, and to the president of the senate of the United States Congress, and to all members of the Texas delegation to the congress, with the request that this resolution be officially entered in the Congressional Record as a memorial to the Congress of the United States.

Kubiak

H.C.R. No. 25

WPHobby
President of the Senate

Gib Lewis
Speaker of the House

I certify that H.C.R. No. 25 was adopted by the House on April 2, 1987, by a non-record vote.

Betty Murray
Chief Clerk of the House

I certify that H.C.R. No. 25 was adopted by the Senate on May 1, 1987.

Betty King
Secretary of the Senate

APPROVED: 5-7-87
Date

W. P. Clements Jr.
Governor

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
4:30 p.m. O'CLOCK
MAY 7 1987
Secretary of State

TESTIMONY BY

ALTON I. SUTNICK, M.D.
SENIOR VICE PRESIDENT FOR HEALTH AFFAIRS AND DEAN
THE MEDICAL COLLEGE OF PENNSYLVANIA

BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON AGING

April 30, 1987

MCP The Medical College of Pennsylvania

(215) 842-6000

Mr. Chairman and Members of the Subcommittee, my name is Alton Sutnick. I am Senior Vice President for Health Affairs and Dean of The Medical College of Pennsylvania. The Medical College of Pennsylvania is an independent, academic health center located on Henry Avenue in the East Falls section of Philadelphia. Founded in 1850 as The Female Medical College of Pennsylvania, it was the first medical college devoted exclusively to the medical education of women. It was renamed The Woman's Medical College of Pennsylvania in 1867, and was for much of the 20th century the only women's medical college in the United States. In 1969, the College became coeducational and the following year the name was changed to The Medical College of Pennsylvania. Today, we have grown to become a 33-acre campus, with both a medical school and a 445-bed hospital. We currently employ 3,269 persons and enroll more than 450 undergraduate medical students and 100 students in our Graduate School of Medical Sciences. The Hospital admits more than 12,000 patients annually and records over 63,000 outpatient visits per year.

I appear before you today to testify on behalf of H.R. 1451--the Older American Amendments of 1987, and to the need for a continued public and private sector commitment to the elderly of our Nation.

As I am sure you are all aware from the extensive publications of data, the American population is aging. In 1985, the 65-74 age group was nearly 8 times larger than it was in 1900. Even more striking, however, is that the 75-84 age group was 11 times larger; and the over-85 age group, the most likely to be frail and infirmed, was 22 times larger than in 1900.

Statistics also show that this rapid growth rate is not expected to decline. By the year 2030, there will be about 65 million older persons--that equals 2-1/2 times the number there were in 1980. If current fertility and immigration levels remain stable, the only age group to experience significant growth in the next century will be those past age 55. This represents a significant challenge for our country. Baby booms have been followed by baby busts, creating a population pattern of large numbers of increasingly older Americans with fewer younger Americans to support them.

We can meet this challenge, but only by devoting substantial resources to the treatment and prevention of those disorders most likely to cause dependency and loss of function. We must work to assure that the quality of life keeps pace with the length of life.

When we think about the elderly and the mental and physical problems which result in loss of function, we immediately think of Alzheimer's Disease. But, in fact, 90 percent of the elderly don't have Alzheimer's Disease. They are prevented from functioning due to such illnesses as depression--approximately one-third of the elderly population suffers from severe mental depression. Mental depression is diagnosable, and easily treated, but often overlooked. Of almost equal frequency, are problems resulting from drug interaction. Not enough attention has been focused on the relationship between drug side effects and brain disease. A frequent misconception is that older persons are drowsy or sleepy most of the time and we have tended to look upon these characteristics as normal symptoms of aging. Research has shown this to be false. Many older persons suffer from disruptive sleep disorders which, with the proper therapy to change sleep patterns, can be corrected. Another misconception in which many of us share, is that elderly persons are slow and dumb. While it may be true that the aged require a bit more time to collect their thoughts, the wealth of knowledge and ability to make judgments is something that only increases with age.

One of the first steps to take in addressing the needs of the aged is the capacity to separate the problems associated with mental dysfunction into what is a "normal" part of growing old and what is a result of disease. We have been finding that more and more of the manifestations of aging are the result of diseases which are potentially treatable. This is the area of gerontology which requires our continued focus in order to improve the mental, as well as physical well being, of the elderly. If I may take just a few minutes I would like to highlight some of the steps The Medical College of Pennsylvania has taken to confront this challenge.

The Medical College of Pennsylvania began its commitment to geriatrics in the 1960's with the establishment of a physiology/pharmacology research program in geriatrics. The basic science research activities witnessed major growth in the 1970's with the establishment of highly competitive research programs in lipids and atherosclerosis. Geriatrics-related basic science research has continued to grow throughout the 1980's. Since FY 1983, The Medical College has received approved funding for geriatrics-related research grants at a level of over $8 million.

In 1982, The Medical College began to build its clinical research program in geriatrics when it developed an exclusive affiliation with the Philadelphia Geriatric Center (PGC), which has a large patient base, and established the Division of Geriatric Medicine. This affiliation, in combination with the assumption of the managerial responsibility of the Eastern Pennsylvania Psychiatric Institute (EPPI) in 1981, provided The Medical College with the resources to integrate its strengths in basic research and clinical programs in geriatrics and mental health. As a result, we are on the cutting edge of science research in geriatric mental health and are already receiving national recognition.

In 1982, in collaboration with the Philadelphia Geriatric Center and the University of Pennsylvania, we became one of the first two recipients of a teaching nursing home award. This five year, $4.4 million program supports not only five geriatric clinical research investigations, but also a data registry base containing information on several hundred variables for over 1,700 patients.

In FY 1985, we were awarded a Clinical Research Center grant in the Study of the Psychopathology of the Elderly. Medical College faculty who serve as investigators on this grant include Dr. M. Powell Lawton and Mrs. Elaine Brody, who are among the country's most prominent social gerontologists, and Drs. George Simpson and Ira Katz, who are preeminent in clinical and psychopharmacological research as it relates to the elderly. The Center, which is funded for three years by the National Institute of Mental Health at approximately $1 million, allows for the implementation of four research programs in the area of depression in the elderly. One research group has determined that elderly nursing home residents with symptoms of major depression exhibit a significant increase in mortality. Further research is being conducted to investigate the nature of depression in the frail elderly and the inter-relationships between depression and medical illness. Treatment studies are being conducted to test the hypothesis that adequate treatment can decrease disability and mortality as well as improve mood. We have also been developing an approach for monitoring the elderly patient to detect reversible causes of cognitive deterioration such as adverse drug effects and metabolic brain disease. Preliminary data suggest that parallel measures of cognitive performance and cerebral activity can improve the sensitivity and specificity for the recognition of treatable cognitive disorders.

Future research directions for the Clinical Research Center include additional research into depression and the reversible cognitive disorders, as well as work designed to introduce research findings into clinical practice. Irreversible causes of disability are very common in the elderly. The primary responsibility of physicians and investigators is to recognize and treat all potentially reversible disorders. Research, as well as clinical and education activities at the Clinical Research Center are devoted to this end.

In addition to all of the foregoing, The Medical College is conducting pioneering research in the areas of aging, physical fitness, information processing speed and pharmacology. We have invested $8.5 million into the modernization of EPPI and have created several laboratories to facilitate research in the area of mental health and the aging process. As part of these facilities, a new clinical analytical laboratory was built to develop research which seeks to gain a greater understanding of the diagnosis, treatment, and care of the needs of geriatric patients suffering from senile dementia, depression and other emotional states of the elderly.

Mr. Chairman and Members of the Committee, I have sought to give you just a small insight into the great strides that are being made in geriatrics and mental health. As we grapple with the knowledge that we can all anticipate living a long life, we need to do all that we can to assure that it is a happy, healthy and fruitful one. This is not an impossible dream, but it will require dedication and hard work. We at The Medical College of Pennsyvlania are prepared to do that. We hope that we can continue to rely upon the dedication of the Congress as well. Thank you for your time and attention.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Statement on

REAUTHORIZATION OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON AGING

Submitted by

ROGER P. KINGSLEY, Ph.D.

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April 30, 1987

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As the professional and scientific association representing over 52,000 speech-language pathologists and audiologists nationwide, the American Speech-Language-Hearing Association (ASHA) is very concerned about services to elderly people with communication disorders. We are pleased that, as part of the reauthorization of the Older Americans Act, the Subcommittee on Aging is planning to examine the problems of people with disabilities who are or should be served under the Act.

Provisions in Current Law on Health Care Services to the Elderly

A major objective of the Older Americans Act of 1965, as amended (P.L. 89-73) (Section 101 (2)) is "The best possible physical and mental health which science can make available and without regard to economic status." Another objective is to make it possible for elderly people to receive health and social services in institutions where necessary and in their communities whenever possible through (Section 101 (4)):

> "Full restorative services for those who require institutionalized care, and a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes."

The basic grant program, Title III, provides for services to older individuals "with the greatest economic or social needs," and defines social need (Section 305 (d)(2)) as:

> "the need caused by noneconomic factors which include physical and mental disabilities, language barriers, and cultural or social isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens his or her capacity to live independently."

The Act also provides for supportive services, such as personnel training and research, which are necessary for appropriate and effective implementation of basic health care services to elderly people, particularly those with disabilities. A major purpose in Title IV (Section 410) is:

> "to improve the quality of service and to help meet critical shortages of adequately trained personnel for programs in the field of aging by--
>
> (1) identifying both short- and long-range manpower needs in the field of aging; (2) providing a broad range of educational and training opportunities to meet those needs; (3) attracting a greater number of qualified personnel into the field of aging; (4) helping to upgrade personnel training programs to make them more responsive to the need in the field of aging; and (5) establishing and supporting multidisciplinary centers of gerontology and providing special emphasis that will improve, enhance, and expand existing training program."

ASHA believes that the foregoing objectives of the Act require Congress to take a close look, during the present reauthorization, at the adequacy of services and personnel providing services to older Americans. This statement focuses on the problems and needs of elderly persons with communication disorders and the workforce available and needed to attend to this large and growing population.

Communication Disorders Among the Elderly

The rapid aging of the American population is by now a well known fact. U.S. Census data for 1985 showed that a total of 28.5 million people are 65 years or older, representing 12% of the population.[1] It is projected that the elderly population will more than double to 65 million people by the year 2030. One in five Americans will be elderly.[2] The groups among the elderly with the most rapid growth will be the "oldest of the old" -- women and racial minorities -- the same groups that suffer the most from problems of poor health, poverty, and social isolation.

Among the most prevalent health problems in the elderly population are speech, language and hearing impairments. Many of these problems are associated with diseases that occur among adults and which may be directly related to the aging process: Alzheimer's disease, a principle cause of dementia; Parkinson's disease and other progressive neurological diseases resulting in oral-motor dysfunction; stroke, resulting in aphasia or the loss of speech and language ability; cancer of the larynx, resulting in laryngectomy; and, presbycusis, or degeneration of the auditory function associated with the aging process. The impact of these conditions on human communications is apparent. Stroke typically impairs the individual's ability to interpret and use language symbols for listening, speaking, reading and writing. The more than one million older persons with severe forms of senility and the estimated two million other senior citizens exhibiting moderate senility typically demonstrate language impairment. Reading comprehension and understanding of oral speech are reduced.[3] One study indicated that only 5% of senile patients had adequate communication ability.[4] Since the prevalence of senility increases with advancing age, the problem will become greater as the number of the very old expands at the projected rate. The number of older Americans being maintained at home or who are deinstitutionalized and returned to the community is also increasing. Many of these people are mentally retarded or otherwise developmentally disabled, and a majority of this population has communication disorders.[5]

The Department of Health and Human Services estimates that at least 25% of persons between 65 and 74 years of age have hearing impairment, twice the occurrence for people in the 45-64 age group. In the 75 years and older population this figure jumps to over 40%. In 1980, the proportion of people 65 years and older with hearing and speech disorders were 43% and 20% respectively, but will grow to 46% and 25% by the year 2000, and to 59% and 39% by 2050.[6]

Older Americans experience multiple problems -- physical limitations, chronic health conditions, lack of economic resources, and loneliness. At a time in their lives when there is a growing need for interpersonal communication, many elderly individuals are affected by conditions that profoundly limit their communicative abilities. These individuals may be unable to share perceptions and memories, inform others of their needs, or continue to take part in vocational, social and recreational activities. Most seriously, the social isolation occasioned by communication disabilities may lead to psychopathology.[7]

Hearing loss results in difficulties in understanding oral speech, particularly in noisy environments. When this occurs in older persons, there is a tendency for friends and even family to view the individual as becoming senile because of inappropriate responses and confusions that may arise. An expert in hearing problems describes the many ways in which hearing loss in older persons negatively affects their daily lives:

> One can understand the fear, apprehension and confusion an older hearing impaired person must experience as a hospital patient trying to determine what is going on; or the frustration of half-heard movies, plays and lectures; the disappointment of not being able to have the full worship experience at church or synagogue; the embarrassment and problems resulting from missed announcements from a public address or paging system in an airport, bus station, train station, or doctor's office; the problems that arise at home when food boils over, bathtubs overflow, and timers, alarm clocks, doorbells and telephones are not heard; the loss of independence due to greater difficulty making telephone calls or driving a car; the potential loss of calming influences and pastime activities, such as

> listening to music, hearing the quiet sounds of nature while on a walk, watching television, dining out, going shopping; the sense of tension and anxiety at parties or when entertaining guests because of the difficulty coping with the background noise and the conversational banter. When such experiences and feelings are considered, it is not surprising that an older person who has a hearing impairment is tempted to give up and withdraw defeated, discouraged, disappointed and dismayed. It is difficult enough to deal with such problems in a friendly and understanding environment, but too often the older person encounters a somewhat hostile environment lacking in understanding and patience.[8]

The prevalence of hearing loss among nursing home residents has been reported in the range between 48% to 82% and approximately 25% of the elderly in nursing homes have speech/language impairments.[9] While the number of older Americans in long-term care facilities continues to grow, the number in community and home based settings is also increasing as a result of the move toward deinstitutionalization.

Availability of Services for the Communicatively Impaired Elderly

Most elderly people are covered through Medicare or Medicaid, although the settings in which reimbursable services can be provided varies a great deal. Physician services related to the diagnosis and treatment of hearing impairment are covered as are diagnostic services by audiologists when evaluations are requested by a physician to determine the cause of a hearing disorder. Rehabilitative services provided by audiologists are provided for patients under certain circumstances. However, hearing aids and evaluations for such aids are not covered by Medicare and are covered in only about half of the states under Medicaid. Speech-language pathology services are covered in a various inpatient and outpatient settings including hospitals, skilled nursing facilities, speech and hearing clinics, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, and home health agencies.

Hearing services for elderly persons are provided primarily in the offices of physicians, audiologists, and hearing aid dealers. To a lesser extent, hearing services are provided in health care and educational settings and in multi-service community agencies. Most hearing services provided by health care institutions are delivered on an outpatient basis, with the emphasis on short-term care. Home health programs offer an optimal setting for the delivery of services to the communicatively impaired elderly, but these services are not generally available. In a study of 206 home health agencies, only 5% provided hearing services.[10] Adult day care centers that serve people who require long-term care but reside at home are another appropriate setting, for service delivery. Some senior centers which offer social services also offer hearing screening and other hearing services.

Elderly individuals who experience speech, language and/or hearing disorders can often maintain a high degree of independence through the use of communication aids and devices. The most common device used by the hearing impaired elderly is, of course, the hearing aid. Assistive listening devices (e.g., audio loops, telephone amplifiers) often enable individuals to hear television and radio, to follow what is being said in large areas and even noisy environments, and to communicate on the telephone. Individuals with speech and language impairments can often benefit by using augmentative communication aids such as communication and language boards and electronic and microcomputer equipment. However, these forms of assistance are often unavailable to the communicatively impaired elderly because service facilities are not informed of their benefit to the potential user. A survey of facilities that provide communication aids to severely speech impaired individuals found that barely half provided services to the elderly.[11]

Research concerning services to elderly persons with communication disorders and supported by Title IV grants is currently being conducted by a number of institutions (including Gallaudet University, The Urban Institute, and United Way of America) which focuses on health service needs and personnel requirements of the elderly population.[12] A recently published study by the Gallaudet Research Institute reports that approximately 9% of senior centers surveyed nationally had special programs and services for elderly hearing impaired persons. Common types of support services and equipment for elderly persons included hearing testing and screening, hearing aid sales and service, telephone devices for the deaf (TTDs and TTYs), speech reading and auditory training.[13]

Personnel Available and Needed to Serve Elderly People with Communication Disorders

As the number of older Americans continues to grow, health care services and qualified personnel to provide these services must also necessarily increase. The need for professionals to provide services to the communicatively impaired elderly must take into account the prevalence of speech, language and hearing disorders, population size, practice settings and delivery systems.

Speech-language pathologists and audiologists are individuals certified and licensed (in 36 states for speech-language pathologists and 37 states for audiologists) to provide professional assistance to persons of all ages with communication disorders. These professionals offer important services to elderly people with primary or secondary communication disorders. Speech-language pathologists provide many specialized services such as (a) helping the aphasic patient to relearn language and speech skills; (b) helping the laryngectomized individual learn an alternative to the normal way of speaking, particularly through the use of augmentative communication devices; and (c) counseling individuals and families with speech and language problems. Audiologists specialize in (a) preventing, identifying, and assessing hearing impairment; (b) rehabilitating the hearing impaired; and (c) fitting hearing aids and training individuals in their use.[14]

Because of changing demographics in the elderly population and the dynamics of the health care system, the actual number of speech-language-hearing personnel that will be needed to provide services to the elderly can only be estimated. At present, ASHA is conducting a work force study which is looking at the current and projected supply of and demand for speech-language-hearing personnel to serve people with communication disorders. Since the results of this study will not be available for a while, the estimates presented here are based on limited data and tentative projections.

ASHA estimates that the supply of speech-language pathologists and audiologists will increase from the current level of about 48,500 to approximately 75,000 in the year 2000. Certified members of the profession must hold at least a master's degree and have had a year of supervised clinical experience in speech-language pathology and audiology. Work force projections can be made by examining the numbers of students entering and graduating from training programs and by examining changes in the supply of professionals providing services. The number of master's degree entrants into the profession has fluctuated around 15% over the past five years. Since this group provides the majority of clinical services, a steady but still inadequate influx of new professionals will be available for service to elderly persons with communication disorders. However, the profession is experiencing a serious drop in the number of doctoral degree students. Since this group forms the majority of faculty members involved in personnel preparation programs, fewer will be available to teach incoming students.

The figures in the accompanying charts represent lower and higher estimates of speech-language pathologists and audiologists needed to serve the elderly, based on the prevalence of communication disorders in the 65 and older population and professional practice patterns including patient caseloads.[15]

Currently, ASHA surveys indicate that over 12% of the caseloads of speech-language pathologists and approximately 32% of the caseloads of audiologists consist of elderly individuals.[16] As the accompanying tables show, the number of professionals needed to serve this population ranges between about 11,000 and 73,000 and 5,750-9,500, respectively for speech-language pathologists and audiologists. Within the next 35 years, the number of professionals needed to work with elderly individuals will approximately double.

Recommendations

ASHA's recommendations for the Older Americans Act focus on services, benefits, and training related to elderly individuals with communication disorders. Some of the proposals have been developed in consultation with other professional provider associations, organizations representing the disability community, and senior citizen organizations. We believe that it is imperative that Congress recognize the increasing prevalence of communication problems among the elderly, the resultant need for more qualified professionals to serve this population, and the need to increase access to services and the availability of benefits such as hearing aids and augmentative communication devices. We are cognizant, however, of limited authorizations and current budget restraints. Therefore, several of our recommendations are for modest expansion of training and demonstration projects under Title IV as opposed to broader expansions under Title III.

Recommendation for Title II

In order for the Administration on Aging to be more aware of and involved in issues concerning elderly people with disabilities, a new subsection should be added to Section 202 (a):

> "(19) Consult with national organizations representing the interests of persons with disabilities, including but not limited to developmental disabilities, including stroke, head injury, physical or sensory impairments, mental disorders, Alzheimer's disease and related disorders, to develop and disseminate information on population characteristics and needs, training of personnel, and to provide technical assistance designed to assist State and area agencies to provide services in collaboration with other state agencies to older persons with disabilities."

Recommendations for Title III

In order for state and area agencies on aging to focus more on the needs of elderly people with disabilities, two new subsections should be added as follows.

Amend Section 305 (a) (2) by adding a new subsection:

> "encourage the development of cooperative arrangements between State area agencies and state health agencies with primary responsibility for individuals with mental retardation, developmental disabilities, or other handicapping conditions, and encourage collaborative programs to meet the needs of vulnerable older individuals with these conditions."

Amend Section 306 (a) (5) concerning services to individuals with the greatest social needs, by adding a new subsection:

> "elderly with mental and physical disabilities, including but not limited to physical or developmental disabilities, stroke, head injury, physical or sensory impairments or Alzheimer's disease."

Recommendations for Title IV

The statement of purpose should be amended to include a reference to people with disabilities. A new subsection should be added to Section 401, relating to meeting the needs for trained personnel in the field of aging through:

> "collaborative projects joining aging with professions specializing in physical and mental disabilities."

A new section 413 should be created to enable the Commissioners of the Administration on Aging and the Administration on Developmental Disabilities to enter into cooperative agreements in order to establish multidisciplinary centers to train personnel to specialize in working with elderly developmentally disabled people.

> "The Commissioner in conjunction and agreement with the Commissioner of the Administration on Developmental Disabilities may make grants to private and public nonprofit agencies, organizations, and institutions of higher education for the purpose of establishing multidisciplinary centers in aging and developmental disabilities. Such centers shall conduct research and policy analysis, provide for the training of personnel, serve as a technical resource at the State level for State agencies, State developmental disabilities planning councils, State mental retardation/developmental disabilities agencies and service providers and at the national level, to the Commissioners and the Congress, and provide for other functions deemed necessary by the Commissioner. Such centers on aging and developmental disabilities shall --
>
> (1) develop and provide education programs for the training of personnel working with older developmentally disabled individuals; (2) conduct research on service practices; (3) provide technical assistance to State and area agencies providing for older individuals with developmental disabilities; and (4) serve as repositories of technical information."

Two new subsections should be added to Section 422, relating to special projects designed to "(2) meet the special health care needs of the elderly, including--

> "the identification and provision of services to elderly individuals, including individuals with lifelong disabilities, with

disorders of speech, language and/or hearing that interfere with their ability to function socially and independently; and

the provision of rehabilitative services, and communication aids and devices, to assist individuals, including individuals with lifelong disabilities, with speech, language and/or hearing disorders."

In addition, we note that, while the Act makes reference to "qualified personnel," there is no definition of this term in the regulations implementing the Act. Currently, there is a lack of data on the qualifications of personnel providing health care services under the Act. However, the Older Americans Act Amendments of 1984 included a provision requiring the Commissioner to (Section 421 (c)) "identify the future needs of older individuals; identify the kinds and comprehensiveness of programs required to satisfy such needs; and identify the kinds and number of personnel required to carry out such programs." We, therefore, urge the Committee to give careful consideration to the findings with respect to the supply and qualifications of health care professionals working in the field of aging.

Notes

1. Personal communication, U.S. Bureau of the Census, Population Division (March 1987).

2. American Association of Retired Persons, *Profile of Older Americans* (1984).

3. American Speech-Language-Hearing Association, *Communication Disorders and Aging* (1985), p. 23.

4. Ferm, L. "Behavioral Activities in Demented Geriatric Patients," *Gerontology*, 16, (1975), p. 185.

5. Committee on Mental Retardation/Developmental Disabilities, ASHA Position Statement, "Serving the Communicatively Handicapped Mentally Retarded Individual," *Asha* (August 1982), pp. 548-49.

6. Fein, D. "Projections of Hearing and Speech Impairments to 2050," *Asha*, 25, (1983), p. 31.

7. ASHA, *Communication Disorders and Aging*, p. 24.

8. Bate, H. "Aural Rehabilitation of the Older Adult," *Seminars in Hearing*, 6, (1985), pp. 193-205.

9. National Center for Health Statistics, unpublished data from the 1973-74 Nursing Home Survey, in *Asha*, *The Prevalence of Communicative Disorders* (1981), p. 43.

10. Office of Technology Assessment, *Hearing Impairment and Elderly People* - A Background Paper (1986), p. 54.

11. Blackstone, S. and Isaacson, R. "Service Delivery in Augmentative Communication," in L. Bernstein (ed.), *The Vocally Impaired* (in press).

12. Administration on Aging, *Active Grants Under Title IV of the Older Americans Act*, Appendix VI (September 30, 1986).

13. Sela, I., *A Study of Programs and Services for the Hearing Impaired Elderly in Senior Centers and Clubs in the U.S.A.*, Gallaudet Research Institute (1986), pp. 142-49.

14. American Speech-Language-Hearing Association, *Communication Problems and Behaviors of the Older American* (1979).

15. Cherow, E., American Speech-Language-Hearing Association, Report to the National Institute on Aging on Meeting the Needs of the Communicatively Impaired Aging Population (1986).

16. American Speech-Language-Hearing Association, Omnibus Survey (1986).

Lower and Higher Estimates of the Number of Audiologists Needed to Serve the Elderly Population

Year	Population in Thousands			Population with Hearing Impairment (HI)			No. FTE Audiologists Required to Serve HI Population
	65-74 yr.	75+yr.	Total	65-74 yr.	75+ yr.	Total	Total
				Lower Estimate			
1980	15,627	10,265	25,892	4,094,274	3,717,983	7,812,257	5,755
2000	18,334	17,918	36,252	4,803,508	6,489,900	11,293,408	8,320
2020	30,093	22,560	52,653	7,884,366	8,171,232	16,055,598	11,828
				Higher Estimate			
1980	15,627	10,265	25,892	4,375,560	4,927,200	9,302,760	9,541
2000	18,334	17,918	36,252	5,133,520	8,600,640	13,734,160	14,086
2020	30,093	22,560	52,653	8,426,040	10,828,800	19,254,840	19,749

FTE = Full-time equivalent

Lower and Higher Estimates of the Number of Speech-Language Pathologists Needed to Serve the Elderly Population

Year	Population in Thousands			Population with Speech-Language Impairment (SLI)			No. FTE S/L Pathologists Required to Serve SLI Popul.
	65-74 yr.	75+yr.	Total	65-74 yr.	75+ yr.	Total	Total
				PRODUCTIVITY APPROACH **Lower Estimate**			
1980	15,627	10,265	25,892	129,704	87,253	216,957	11,126
2000	18,334	17,918	36,252	152,172	152,203	304,475	15,614
2020	30,093	22,560	52,653	249,772	191,760	441,532	22,643
				Higher Estimate			
1980						1,424,060	73,029
2000						1,993,860	102,249
2020						2,895,915	148,508

FTE = Full-time equivalent

Senator **Matsunaga**. Thank you very much, all of you, for coming. I appreciate it.

[Whereupon, at 4:55 p.m., the Subcommittee was adjourned.]

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